

UtahAccess+ Proposal

**Health Reform Task Force
October 6, 2015**

This material is not a draft bill. It represents the beginning of a draft bill, but additional policy and implementation decisions need to be made before final legislation can be prepared.

1 **Preferred Drug List**

2 **26-18-2.4. Medicaid drug program -- Preferred drug list.**

3 (1) A Medicaid drug program developed by the department under Subsection
4 26-18-2.3(2)(f):

5 (a) shall, notwithstanding Subsection 26-18-2.3(1)(b), be based on clinical and
6 cost-related factors which include medical necessity as determined by a provider in accordance
7 with administrative rules established by the Drug Utilization Review Board;

8 (b) may include therapeutic categories of drugs that may be exempted from the drug
9 program;

10 (c) may include placing some drugs, except the drugs described in Subsection (2)(b), on
11 a preferred drug list to the extent determined appropriate by the department;

12 (d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, shall
13 immediately implement ~~[the]~~ prior authorization requirements for a nonpreferred drug that is in
14 the same therapeutic class as a drug that is:

15 (i) on the preferred drug list on the date that this act takes effect; or

16 (ii) added to the preferred drug list after this act takes effect; and

17 (e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior
18 authorization requirements ~~[established]~~ under ~~[Subsections (1)(c) and (d) which shall]~~
19 Subsection (1)(d) that:

20 (i) permit a health care provider or the health care provider's agent to obtain a prior
21 authorization override of the preferred drug list through the department's pharmacy prior
22 authorization review process~~[-and which shall:]~~;

23 ~~[(i)]~~ (ii) provide either telephone or fax approval or denial of the request within 24 hours
24 of the receipt of a request that is submitted during normal business hours of Monday through
25 Friday from 8 a.m. to 5 p.m.;

26 ~~[(ii)]~~ (iii) provide for the dispensing of a limited supply of a requested drug as
27 determined appropriate by the department in an emergency situation, if the request for an
28 override is received outside of the department's normal business hours; and

29 ~~[(iii)]~~ (iv) require the health care provider to provide the department with documentation
30 of the medical need for the preferred drug list override in accordance with criteria established by
31 the department in consultation with the department's Pharmacy and Therapeutics Committee.

32 (2) (a) For purposes of this Subsection (2):

33 (i) "Immunosuppressive drug":

34 (A) means a drug that is used in immunosuppressive therapy to inhibit or prevent activity
35 of the immune system to aid the body in preventing the rejection of transplanted organs and
36 tissue; and

37 (B) does not include drugs used for the treatment of autoimmune disease or diseases that
38 are most likely of autoimmune origin.

39 (ii) "Psychotropic drug" means the following classes of drugs: ~~[atypical anti-psychotic]~~
40 anti-psychotics, anti-depressants, anti-convulsant/mood ~~[stabilizer]~~ stabilizers, anti-anxiety
41 drugs, attention deficit hyperactivity disorder stimulants, or sedative/hypnotics.

42 (iii) "Stabilized" means a health care provider has documented in the patient's medical

43 chart that a patient has achieved a stable ~~[or steadfast]~~ medical state ~~[within the past 90 days~~
44 ~~using]~~ by use of a particular psychotropic drug.

45 (b) A preferred drug list developed under the provisions of this section may not include[:
46 ~~(i) except as provided in Subsection (2)(e), a psychotropic or anti-psychotic drug; or (ii)]~~ an
47 immunosuppressive drug.

48 (c) The ~~[state]~~ Medicaid program shall reimburse for a prescription for an
49 immunosuppressive drug as written by ~~[the]~~ a health care provider for a patient who has
50 undergone an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to
51 patients who have undergone an organ transplant, the prescription for a particular
52 immunosuppressive drug as written by ~~[a]~~ the health care provider meets the criteria of
53 demonstrating to the ~~[Department of Health]~~ department a medical necessity for dispensing the
54 prescribed immunosuppressive drug.

55 (d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the
56 ~~[state]~~ Medicaid drug program may not require the use of step therapy for immunosuppressive
57 drugs without the written or oral consent of the health care provider and the patient.

58 ~~[(e) The department may include a sedative hypnotic on a preferred drug list in~~
59 ~~accordance with Subsection (2)(f).]~~

60 ~~[(f)]~~ (e) The department shall grant a prior authorization for a ~~[sedative hypnotic]~~
61 psychotropic drug that is not on the preferred drug list ~~[under Subsection (2)(e),]~~ if the health
62 care provider has documentation ~~[related to]~~ showing at least one of the following ~~[conditions]~~
63 for the Medicaid client:

64 (i) a trial and failure of at least one preferred agent in the drug class, including the name
65 of the preferred drug that was tried, the length of therapy, and the reason for the discontinuation;

66 (ii) detailed evidence of a potential drug interaction between current medication and the
67 preferred drug;

68 (iii) detailed evidence of a condition or contraindication that prevents the use of the
69 preferred drug;

70 (iv) objective clinical evidence that a patient is at high risk of adverse events due to a
71 therapeutic interchange with a preferred drug;

72 (v) the patient is a new or previous Medicaid client with an existing diagnosis previously
73 stabilized with a nonpreferred drug; or

74 (vi) other valid reasons as determined by the department.

75 ~~[(g)]~~ (f) A prior authorization granted under Subsection (2)~~[(f)]~~(e) is valid for ~~[one year]~~
76 two years from the date the department grants the prior authorization and shall be renewed in
77 accordance with Subsection (2)~~[(f)]~~(e).

78 (g) Accountable Care organizations that contract with the state Medicaid program shall
79 grant prior authorization for a psychotropic drug that is not on the preferred drug list established
80 by the department, if the health care provider has documentation showing at least one of the
81 conditions listed in Subsections (2)(e)(i) through (vi) for the Medicaid client.

82 (3) The department shall report to the Health and Human Services Interim Committee
83 and to the Social Services Appropriations Subcommittee prior to November 1, ~~[2013]~~ 2017, and
84 prior to November 1 of each year thereafter, regarding the savings to the Medicaid program
85 resulting from the use of ~~[the]~~ a preferred drug list ~~[permitted by]~~ developed under Subsection

86 (1).

87 (4) (a) Savings to the Medicaid program from adding psychotropic drugs, other than
88 sedative hypnotics, to the preferred drug list shall be calculated for each fiscal year by the
89 department and reported to the Legislature under Subsection (3).

90 (b) For each fiscal year, the Legislature shall appropriate to the AccessUtah+ Fund
91 created in Section 26-18c-2003, an amount equal to 100% of the savings calculated for the
92 immediately preceding fiscal year.

94 CHAPTER 18c ACCESSUTAH+

95 Part 1. General Provisions

96 **26-18c-101. Title.**

97 This chapter is known as "AccessUtah+".

98 **26-18c-102. Definitions.**

99 For purposes of this chapter:

100 (1) "Adult expansion population" means an individual who:

101 (a) is described in 42 U.S.C. Sec. 1396a(10)(A)(i)(VIII); and

102 (b) is not otherwise eligible for Medicaid as a mandatory categorically needy individual.

103 (2) "CMS" means the Centers for Medicare and Medicaid Services within the United
104 States Department of Health and Human Services.

105 (3) "Division" means the Division of Health Care Financing within the department,
106 established under Section 26-18-2.1.

107 (4) "Enhanced match rate" means the federal match for the adult expansion population
108 established in 42 U.S.C. Sec. 1396d(y).

109 (5) "Employer sponsored insurance" means minimum essential coverage, as that term is
110 defined in 26 C.F.R. 1.5000A-2, that is offered by an employer to its employees.

111 (6) "Federal poverty level" means the poverty guidelines established by the Secretary of
112 the United States Department of Health and Human Services under 42 U.S.C. 9909(2)

113 (7) "Medically frail" means an individual in the adult expansion population who meets
114 the medically exempt criteria of 42 C.F.R. 440.315:

115 (a) as determined by the department; and

116 (b) based on methodology administered by the department or another entity selected by
117 the department.

118 (8) "PPACA" means the same as that term is defined in Section 31A-1-301.

119 (9) (a) "Qualifying event" means a life event that triggers a special enrollment period
120 under 45 C.F.R. 155.420.

121 (10) "Silver level plan" means a health insurance plan for which an individual may
122 receive federal premium and cost sharing subsidies in the federal health insurance market place
123 established under PPACA.

124 (11) "AccessUtah+" means the Medicaid expansion program described in Part 3,
125 Description of AccessUtah+, and the funding of AccessUtah+ as described in Parts 4 through 20
126 of this chapter.

127 Part 2. Duties and Authority of Department

128 **26-18c-201. Duty to request and implement Medicaid waivers.**

129 No later than December 31, 2015, the department shall submit to CMS a request for
130 waivers from federal statutory and regulatory law necessary to implement and fund a state
131 Medicaid plan to cover the adult expansion population in accordance with this chapter. The
132 request for waivers shall include a request to amend the state's existing Medicaid waivers for the
133 purpose of carrying forward credits the state has accumulated under the state's existing spending
134 authority for work on health care quality improvements.

135 **26-18c-202. Facilitating enrollment in the AccessUtah+.**

136 The Department shall facilitate enrollment in AccessUtah+ and facilitate the selection of
137 a commercial health insurance plan by certain individuals enrolled in AccessUtah+ by
138 coordinating with the Medicaid eligibility system administered by the Department of Workforce
139 Services, and with the Avenue H web portal created by Section 63N-11-104 and administered by
140 the Office of Consumer Health Services within the Governor's Office of Economic Development.

141 **26-18c-204. Authority of department to negotiate waivers with provisions that**
142 **differ from the requirements of this chapter.**

143 (1) The department has authority to negotiate with CMS regarding waivers necessary to
144 implement AccessUtah+ as described in this chapter.

145 (2) The department may not implement AccessUtah+ unless the department, prior to
146 implementing AccessUtah+, reports to the Legislature's Executive Appropriations Committee
147 regarding whether CMS approved or modified each waiver requested by the department.

148 (3) Except as provided in Subsection (3)(c), after reporting under Subsection (2), the
149 department may implement AccessUtah+ if the executive director of the department determines
150 that the department:

151 (a) obtained approval from CMS for the waivers necessary to implement AccessUtah+ as
152 described in this chapter; or

153 (b) obtained approval from CMS for substantially all the waivers necessary to implement
154 AccessUtah+ as described in this chapter.

155 (c) The department may not implement AccessUtah+ if the department does not obtain
156 waivers and approval from CMS to implement funding mechanism under Parts 4 through 20 of
157 this chapter and receive the enhanced match rate for the funding mechanisms.

158 **Part 3. Description of AccessUtah+**

159 **26-18c-301. Medically frail individuals.**

160 (1) An individual in the adult expansion population who is medically frail shall receive
161 Medicaid benefits and services in the state's traditional Medicaid program.

162 (2) The department may not limit enrollment of a medically frail individual in the
163 program through the use of open enrollment periods.

164 (3) The department shall implement a pilot program that integrates medical and
165 behavioral health care services for the medically frail in selected geographic areas in the state.

166 **26-18c-302. Individuals with employer sponsored insurance.**

167 (1) An individual in the adult expansion population who is not medically frail and who is
168 offered employer sponsored insurance, shall enroll in the employer sponsored insurance.

169 (2) An individual enrolled in employer sponsored insurance under Subsection (1) shall
170 receive wrap-around coverage through AccessUtah+ in accordance with Subsection (3).

171 (3) (a) If an individual is under 100% of the federal poverty level, the individual shall

172 receive Medicaid wrap-around coverage that provides cost sharing and benefits as required by
173 CMS.

174 (b) If an individual is at or above 100% of the federal poverty level, the individual shall
175 receive Medicaid wrap-around coverage that provides cost sharing and benefits substantially
176 equivalent to the cost sharing and benefits provided to an individual who is enrolled in a silver
177 level plan under Section 26-18c-303.

178 (4) If the department determines that the differences between the Medicaid wrap-around
179 coverages described in Subsections (3)(a) and (b) are administratively burdensome, the
180 department:

181 (a) shall report the department's determination to the Legislature in accordance with
182 Section 26-18-13; and

183 (b) may provide wrap-around coverage with more uniform levels of cost sharing and
184 benefits.

185 **26-18c-303. Individuals without employer sponsored insurance who are above the**
186 **federal poverty level.**

187 (1) (a) If an individual in the adult expansion population is not medically frail, does not
188 have an offer of employer sponsored insurance, and is at or above the federal poverty level, the
189 individual shall, upon application to participate in AccessUtah+, receive:

190 (i) premium subsidies to enroll in a commercial health insurance plan that is actuarially
191 equivalent to a silver level plan; and

192 (ii) cost sharing subsidies equivalent to the cost sharing subsidies that would be available
193 to the individual on the federal market place.

194 (b) Premium and cost sharing subsidies under Subsection (1)(a) shall be sufficient to
195 ensure that:

196 (i) the individual pays at least, but no more than, 2% of the individual's household
197 income toward premiums; and

198 (ii) total cost sharing by the individual, including deductibles, copayments, and
199 coinsurance, but excluding premiums, does not exceed 6% of medical expenses covered by the
200 plan.

201 (2) (a) Coverage purchased under this section shall be subject to an open enrollment
202 period.

203 (b) (i) Except as provided in Subsection (2)(b)(ii), UtahAcces+ shall allow an individual
204 to enroll in a commercial health insurance plan outside of the annual open enrollment period if
205 the individual experiences a qualifying event.

206 (ii) If an employer drops employer sponsored insurance for its employees, an employee
207 who is eligible for AccessUtah+ and who is above 100% of the federal poverty level, may not
208 enroll in a commercial plan in AccessUtah+ for six months following the date the employer
209 dropped employer sponsored insurance.

210 (3) Coverage under Subsection (1):

211 (a) begins on the first of the month in which the individual is approved for the program
212 and makes an initial premium payment; and

213 (b) may not be applied retroactively from the first of the month in which the first
214 premium payment was made.

215 (4) If an individual fails to make a monthly premium payment after the initial premium
216 payment, the individual shall receive a 60-day grace period during which to make the premium
217 payment before coverage under the commercial health insurance plan terminates.

218 (5) A commercial health insurance plan offered under this section:

219 (a) may not:

220 (i) make a facility payment for non-emergent use of an emergency department; or

221 (ii) provide non-emergent transportation; and

222 (b) may compensate an insurance producer for enrolling the individual in the plan.

223 **26-18c-304. Individuals without employer sponsored insurance who are below the**
224 **federal poverty level.**

225 (1) (a) If an individual in the adult expansion population does not have an offer of
226 employer sponsored insurance, is not medically frail, and is below the federal poverty level, the
227 individual shall, upon application to participate in AccessUtah+, receive:

228 (i) premium subsidies to enroll in a commercial health insurance plan that is actuarially
229 equivalent to a silver level plan; and

230 (ii) cost sharing subsidies described in Subsection (1)(b).

231 (b) Premium and cost sharing subsidies shall be sufficient to ensure that the individual
232 pays at least, but no more than, the maximum amount in premiums, deductibles, copayments,
233 coinsurance, and other cost sharing permitted by CMS for an individual below the federal
234 poverty level.

235 (2) Coverage under Subsection (1) may not be:

236 (a) limited by an open enrollment period; or

237 (b) applied retroactively from the date of enrollment.

238 (3) A commercial health insurance plan offered under this section:

239 (a) may not:

240 (i) make a facility payment for non-emergent use of an emergency department; or

241 (ii) provide non-emergent transportation; and

242 (b) may compensate an insurance producer for enrolling the individual in the plan.

243 **26-18c-305. Keeping families together.**

244 (1) (a) If an individual in the adult expansion population is not medically frail, is above
245 100% of the federal poverty level, and has one or more children who qualify for the Medicaid
246 program or the Children's Health Insurance Program, the individual shall, upon application to
247 participate in AccessUtah+:

248 (i) enroll the individual's children in the same commercial health insurance plan as the
249 plan selected by the individual; and

250 (ii) receive premium and cost sharing subsidies in accordance with Subsection (2) for the
251 individual and the children.

252 (b) If an individual in the adult expansion population is not medically frail, is below
253 100% of the federal poverty level, and has one or more children who qualify for the Medicaid
254 program or the Children's Health Insurance Program, the individual may, at the individual's
255 option:

256 (i) enroll the individual's children in the same commercial health insurance plan as the
257 plan selected by the individual; and

258 (ii) receive premium and cost sharing subsidies in accordance with Subsection (2) for the
259 individual and the individual's children.

260 (2) Premium and cost sharing subsidies shall be sufficient to:

261 (a) enable the individual to purchase coverage in accordance with Section 26-18c-303 or
262 26-18c-304; and

263 (b) ensure that the children receive any additional Medicaid benefits or cost sharing
264 subsidies that are required by CMS.

265 **26-18c-306. Work Assistance.**

266 An enrollee in AccessUtah+ shall be offered employment services at the time of
267 enrollment.

268 **26-18c-307. Waivers for seamless benefit transition.**

269 (1) (a) After the state obtains the waivers required by this chapter and while the state
270 establishes the administrative process for implementing AccessUtah+ and the related funding
271 mechanisms created by this chapter, an individual in the adult expansion population shall be
272 covered as follows:

273 (i) if, at the time of enrollment in AccessUtah+, the individual is at or above 100% of the
274 federal poverty level, is enrolled in a plan on the federal health insurance market place, and is
275 receiving federal premium or cost sharing subsidies, the individual shall maintain coverage in the
276 plan on the federal health insurance marketplace with federal premium and cost sharing subsidies
277 and without funding from the state;

278 (ii) if, at the time of enrollment in AccessUtah+, the individual is at or above 100% of
279 the federal poverty level, is not enrolled in a plan on the federal health insurance marketplace,
280 and is not receiving federal premium or cost sharing subsidies, the individual shall purchase a
281 plan on the federal health insurance marketplace with federal premium and cost sharing subsidies
282 and without funding from the state;

283 (iii) if, at the time of enrollment in AccessUtah+, the individual is medically frail or is
284 below 100% of the federal poverty level, the individual shall enroll in the state's traditional
285 Medicaid program at the enhanced federal match rate.

286 (2) (a) If the Legislature decides to end the AccessUtah+ program for any reason, the
287 department may implement a process for discontinuing AccessUtah+ in accordance with
288 Subsection (2).

289 (b) The department, in consultation with the Legislature, shall pick a date on which to
290 begin the discontinuation process.

291 (c) For an individual who is enrolled in AccessUtah+ on or before the date established by
292 the department under Subsection (2)(b):

293 (i) the individual shall stay in AccessUtah+ as long as the individual remains eligible for
294 AccessUtah+; and

295 (ii) the state shall continue to receive the enhanced federal match rate for that individual.

296 (d) An individual who is in the adult expansion population, is above 100% of the federal
297 poverty level, and is not enrolled in AccessUtah+ on the date established by the department under
298 Subsection (2)(b), may enroll in coverage in the federal market place with premium and cost
299 sharing subsidies from the federal government and without funding from the state.

300 (e) An individual who is in the adult expansion population, who is not in AccessUtah+,

301 and who is below 100% of the federal poverty level, shall receive an alternative Medicaid benefit
302 in accordance with Subsection (3).

303 (3) The alternative Medicaid plan offered to new enrollees under Subsection (2)(e) shall:

304 (a) include limited benefits similar to those offered under the Medicaid Primary Care
305 Network waiver;

306 (b) include benefits in addition to those offered under Subsection (3)(a) if the benefit is
307 prioritized by the department based on a system that evaluates the state budget and the cost and
308 efficacy of the potential benefit; and

309 (c) receive federal funding at a match rate equal to the state's match rate for enrollees not
310 in the adult expansion population.

311 **Part 4. Inpatient Hospital Services.**

312 **26-18c-401. Title.**

313 This part is known as "Inpatient Hospital Services."

314 **26-18c-402. Application.**

315 (1) Other than for the imposition of the assessment described in this part, nothing in
316 this part shall affect the nonprofit or tax exempt status of any nonprofit charitable,
317 religious, or educational health care provider under:

318 (a) Section 501(c), as amended, of the Internal Revenue Code;

319 (b) other applicable federal law;

320 (c) any state law;

321 (d) any ad valorem property taxes;

322 (e) any sales or use taxes; or

323 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by the
324 state or any political subdivision, county, municipality, district, authority, or any agency or
325 department thereof.

326 (2) All assessments paid under this part may be included as an allowable cost of a
327 hospital for purposes of any applicable Medicaid reimbursement formula.

328 (3) This part does not authorize a political subdivision of the state to:

329 (a) license a hospital for revenue;

330 (b) impose a tax or assessment upon a hospital; or

331 (c) impose a tax or assessment measured by the income or earnings of a hospital.

332 **26-18c-403. Definitions.**

333 As used in this part:

334 (1) "Assessment" means the hospital inpatient provider assessment established by this
335 part.

336 (2) "Discharges" means the number of total hospital discharges reported on:

337 (a) worksheet S-3 Part I, column 15, lines 12, 14, and 14.01 of the 2552-96 Medicare
338 cost report or on Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare
339 cost report for the applicable assessment year; or

340 (b) a similar report adopted by the department by administrative rule, if the report under
341 Subsection (2)(a) is no longer available.

342 (4) "Division" means the Division of Health Care Financing of the department.

343 (5) "Hospital":

344 (a) means a privately owned:
345 (i) general acute hospital operating in the state as defined in Section 26-21-2; and
346 (ii) specialty hospital operating in the state, which shall include a privately owned
347 hospital whose inpatient admissions are predominantly:
348 (A) rehabilitation;
349 (B) psychiatric;
350 (C) chemical dependency; or
351 (D) long-term acute care services; and
352 (b) does not include:
353 (i) a residential care or treatment facility as defined in Section 62A-2-101;
354 (ii) a hospital owned by the federal government, including the Veterans Administration
355 Hospital; or
356 (iii) a hospital that is owned by the state government, a state agency, or a political
357 subdivision of the state, including:
358 (A) a state-owned teaching hospital; and
359 (B) the Utah State Hospital.
360 (6) "Medicare cost report" means CMS-2552-96 or CMS-2552-10, the cost report for
361 electronic filing of hospitals.
362 **26-18c-404. Assessment.**
363 (1) A uniform, broad based, assessment is imposed on each hospital:
364 (a) in the amount designated in Section 26-18c-407; and
365 (b) in accordance with Section 26-18c-406.
366 (2) Subject to Section 26-18c-405, the assessment imposed by this part is due and
367 payable on a quarterly basis.
368 **26-18c-405. Collection of assessment -- Deposit of Revenue -- Rulemaking.**
369 (1) The collecting agent for assessment imposed under Section 26-18c-404 is the
370 department which is vested with the administration and enforcement of this part, including the
371 right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative
372 Rulemaking Act, necessary to:
373 (a) implement and enforce the provisions of this part;
374 (b) audit records of a facility:
375 (i) that is subject to the assessment imposed by this part; and
376 (ii) does not file a Medicare cost report; and
377 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
378 Medicare cost report.
379 (2) The department shall deposit assessments collected under this part in the expendable
380 special revenue fund created in Section 26-18c-2003.
381 (3) The department may, by rule, extend the time for paying the assessment.
382 **26-18c-406. Quarterly notice.**
383 Quarterly assessments imposed by this chapter shall be paid to the division within 15
384 business days after the original invoice date that appears on the invoice issued by the division.
385 **26-18c-407. Calculation of assessment.**
386 (1) (a) An annual assessment is payable on a quarterly basis for each hospital in an

387 amount calculated at a uniform assessment rate for each hospital discharge, in accordance with
388 this section.

389 (b) The uniform assessment rate for fiscal years beginning on or after:

390 (i) July 1, 2016 and before July 1, 2018 shall be \$23.93 per discharge; and

391 (ii) July 1, 2018 in the amount established by the Legislature under Part 20, UtahAccess+
392 Fund, Taxes, and Annual Adjustment of Taxes.

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

395 (2) (a) For each state fiscal year, discharges shall be determined using the data from each
396 hospital's Medicare cost report contained in the Centers for Medicare and Medicaid Services'
397 Healthcare Cost Report Information System file, or the report's equivalent if the report is
398 replaced in the future by CMS. The hospital's discharge data will be derived as follows:

399 (i) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year
400 ending between July 1, 2014, and June 30, 2015;

401 (ii) for state fiscal year 2018, the hospital's cost report data for the hospital's fiscal year
402 ending between July 1, 2015, and June 30, 2016; and

403 (iii) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
404 fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.

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

407 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
408 applicable to the assessment year; and

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

410 (c) If a hospital is not certified by the Medicare program and is not required to file a
411 Medicare cost report:

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

414 (ii) the division shall determine the hospital's discharges from the information submitted
415 under Subsection (2)(c)(i); and

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

418 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
419 owns more than one hospital in the state:

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

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

422 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the same
423 Medicaid provider number:

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

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

427 **Part 5. Outpatient Hospital Services.**

428 **26-18c-501. Title.**

429 This part is known as "Outpatient Hospital Services."

430 **26-18c-502. Application.**

431 (1) Other than for the imposition of the assessment described in this part, nothing in this
432 part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or
433 educational health care provider under:

434 (a) Section 501(c), as amended, of the Internal Revenue Code;

435 (b) other applicable federal law;

436 (c) any state law;

437 (d) any ad valorem property taxes;

438 (e) any sales or use taxes; or

439 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by the
440 state or any political subdivision, county, municipality, district, authority, or any agency or
441 department thereof.

442 (2) All assessments paid under this part may be included as an allowable cost of a
443 hospital for purposes of any applicable Medicaid reimbursement formula.

444 (3) This part does not authorize a political subdivision of the state to:

445 (a) license a hospital for revenue;

446 (b) impose a tax or assessment upon a hospital; or

447 (c) impose a tax or assessment measured by the income or earnings of a hospital.

448 **26-18c-503. Definitions.**

449 As used in this part:

450 (1) "Cost" means costs reported by a hospital to the CMS Healthcare Cost Report
451 Information System and published by CMS in its Medicare Cost Report for the applicable
452 assessment year at Worksheet D, Part V, Columns 5 through 7, Line 202 of the Medicare cost
453 report.

454 (2) "Division" means the Division of Health Care Financing of the department.

455 (3) "Facility assessment" means the hospital outpatient provider assessment established
456 by this part.

457 (4) "Hospital":

458 (a) means a privately owned:

459 (i) general acute hospital operating in the state as defined in Section 26-21-2; and

460 (ii) specialty hospital operating in the state, which shall include a privately owned
461 hospital whose inpatient admissions are predominantly:

462 (A) rehabilitation;

463 (B) psychiatric;

464 (C) chemical dependency; or

465 (D) long-term acute care services; and

466 (b) does not include:

467 (i) a residential care or treatment facility as defined in Section 62A-2-101;

468 (ii) a hospital owned by the federal government, including the Veterans Administration
469 Hospital; or

470 (iii) a hospital that is owned by the state government, a state agency, or a political
471 subdivision of the state, including:

472 (A) a state-owned teaching hospital; and

473 (B) the Utah State Hospital.
474 (5) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of
475 hospitals.

476 **26-18c-504. Assessment.**

477 (1) A uniform, broad based, assessment is imposed on each hospital:

478 (a) in the amount designated in Section 26-18c-507; and

479 (b) in accordance with Section 26-18c-506.

480 (2) Subject to Section 26-18c-505, the assessment imposed by this part is due and
481 payable on a quarterly basis.

482 **26-18c-505. Collection of assessment -- Deposit of Revenue -- Rulemaking.**

483 (1) The collecting agent for assessment imposed under Section 26-18c-504 is the
484 department which is vested with the administration and enforcement of this part, including the
485 right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative
486 Rulemaking Act, necessary to:

487 (a) implement and enforce the provisions of this part;

488 (b) audit records of a facility:

489 (i) that is subject to the assessment imposed by this part; and

490 (ii) does not file a Medicare cost report; and

491 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
492 Medicare Cost Report.

493 (2) The department shall deposit assessments collected under this part in the expendable
494 special revenue fund created in Section 26-18c-2003.

495 (3) The department may, by rule, extend the time for paying the assessment.

496 **26-18c-506. Quarterly notice.**

497 Quarterly assessments imposed by this chapter shall be paid to the division within 15
498 business days after the original invoice date that appears on the invoice issued by the division.

499 **26-18c-507. Calculation of assessment.**

500 (1) (a) An annual assessment is payable on a quarterly basis for each hospital in an
501 amount calculated at a uniform assessment rate for each dollar of reported cost, in accordance
502 with this section.

503 (b) The uniform assessment rate for fiscal years beginning on or after:

504 (i) July 1, 2016 and before July 1, 2018 shall be 3.1650 per dollar of cost; and

505 (ii) July 1, 2018 in the amount established by the Legislature under Part 20, UtahAccess+
506 Fund, Taxes, and Annual Adjustment of Taxes.

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

509 (2) (a) For each state fiscal year, cost shall be determined using the data from each
510 hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid Services'
511 Healthcare Cost Report Information System file. The hospital's cost data will be derived as
512 follows:

513 (i) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year
514 ending between July 1, 2014, and June 30, 2015;

515 (ii) for state fiscal year 2018, the hospital's cost report data for the hospital's fiscal year

516 ending between July 1, 2015, and June 30, 2016; and
517 (iii) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
518 fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.
519 (b) If a hospital's fiscal year Medicare cost report is not contained in the Centers for
520 Medicare and Medicaid Services' Healthcare Cost Report Information System file:
521 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
522 applicable to the assessment year; and
523 (ii) the division shall determine the hospital's discharges.
524 (c) If a hospital is not certified by the Medicare program and is not required to file a
525 Medicare cost report:
526 (i) the hospital shall submit to the division its applicable fiscal year discharges with
527 supporting documentation;
528 (ii) the division shall determine the hospital's discharges from the information submitted
529 under Subsection (2)(c)(i); and
530 (iii) the failure to submit discharge information shall result in an audit of the hospital's
531 records and a penalty equal to 5% of the calculated assessment.
532 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
533 owns more than one hospital in the state:
534 (a) the assessment for each hospital shall be separately calculated by the department; and
535 (b) each separate hospital shall pay the assessment imposed by this chapter.
536 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the same
537 Medicaid provider number:
538 (a) the department shall calculate the assessment in the aggregate for the hospitals using
539 the same Medicaid provider number; and
540 (b) the hospitals may pay the assessment in the aggregate.

Part 6. Physician Services.

26-18c-601. Title.

This part is known as "Physician Services."

26-18c-602. Definitions

As used in this part:

(1) (a) "Physician services provider" means:

(i) a naturopathic physician;

(ii) a physician; or

(iii) a physician assistant.

(b) "Physician services provider" does not include a health care practitioner licensed under Title 58, Chapter 81, Retired Volunteer Health Care Practitioner Act.

(2) "Naturopathic physician" means an individual licensed under Title 58, Chapter 71, Naturopathic Physician Practice Act.

(3) "Physician" means an individual licensed as a physician or a surgeon under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(4) "Physician assistant" means an individual licensed under Title 58, Chapter 70a, Physician Assistant Act."

559 **26-18c-603. Tax.**

560 (1) Each year, there is levied a tax on a physician services provider, payable at the time
561 the physician services provider's license is issued or renewed.

562 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each
563 physician services provider shall pay a tax of \$797 per fiscal year.

564 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
565 under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

566 **Part 7. Home Health Care Services**

567 **26-18c-701. Title.**

568 This part is known as "Home Health Care Services."

569 **26-18c-702. Definitions**

570 As used in this part:

571 (1) "Durable medical equipment" means the same as that term is defined in 42 U.S.C.
572 Sec. 1395x and 32 C.F.R. Sec. 199.2.

573 (2) "Durable medical equipment provider" means a person that performs durable medical
574 equipment services.

575 (3) "Durable medical equipment services" means renting or selling durable medical
576 equipment.

577 (4) "Home health services" means licensed nursing services, therapeutic services of
578 physical therapy, speech therapy, occupational therapy, medical social services, or home health
579 aide services.

580 (5) "Home health services provider" means a home health agency as defined in Section
581 26-21-2.

582 **26-18c-703. Tax.**

583 In accordance with Part 19, Taxation and Collection, a tax is imposed on:

584 (1) each durable medical equipment provider based on the durable medical equipment
585 provider's apportioned gross receipts related to durable medical equipment services; and

586 (2) each home health services provider based on the home health services provider's
587 gross receipts related to home health services.

588 **Part 8. Outpatient Prescription Drugs.**

589 **26-18c-801. Title.**

590 This part is known as "Outpatient Prescription Drugs."

591 **26-18c-802. Definitions.**

592 As used in this part:

593 (1) "Brand name drug" means a patented prescription drug sold under the proprietary, or
594 trade, name given to it by a pharmaceutical manufacturing company and approved by the Federal
595 Drug Administration.

596 (2) "Brand name pharmaceutical manufacturing company" means a pharmaceutical
597 manufacturing company that produces brand name drugs.

598 (3) "Generic name drug" means any drug:

599 (a) sold, licensed, or marketed under an abbreviated new drug application approved by
600 the Food and Drug Administration under section 505(c) of the Federal Food, Drug, and Cosmetic
601 Act; and

602 (b) marketed, sold, or distributed with a labeler code, product code, trade name,
603 trademark, or packaging, other than repackaging, different from the brand name drug.
604 (3) Alternative Definition: "Generic name drug" means any drug that is:
605 (a) a bioequivalent to a brand name drug in dosage form, safety, strength, and
606 composition of active ingredients;
607 (b) marketed, sold or distributed under a different labeler code, product code, trade name,
608 trademark, or packaging; and
609 (c) produced after the patent for the brand name drug expires.
610 (4) "Generic name pharmaceutical manufacturing company" means a pharmaceutical
611 manufacturing company that produces generic name drugs.
612 (5) "Outpatient prescription drugs provider" means a brand name pharmaceutical
613 manufacturing company, generic name pharmaceutical manufacturing company, pharmacy, or
614 pharmacy benefit manager.
615 (6) "Outpatient prescription drugs services" means the sale of prescription drugs by an
616 outpatient prescription drugs provider.
617 (7) (a) "Pharmaceutical manufacturing company" means a person that:
618 (i) produces, prepares, propagates, converts, or processes a drug, either directly or
619 indirectly, by extraction from substances of natural origin or independently by means of chemical
620 or biological synthesis, or by a combination of extraction and chemical synthesis, and includes
621 any packaging or repackaging of the substance or labeling or relabeling its container; and
622 (ii) promotes or markets the drugs.
623 (b) "Pharmaceutical manufacturing company" includes a brand name pharmaceutical
624 manufacturing company and a generic name manufacturing company, as defined in this section.
625 (7) (a) Alternative Definition: "Pharmaceutical manufacturing company" means a person
626 who performs substantially all of the following operations that are required to produce a brand
627 name or generic name drug product:
628 (i) mixing;
629 (ii) granulating;
630 (iii) milling;
631 (iv) molding;
632 (v) lyophilizing;
633 (vi) tableting;
634 (vii) encapsulating;
635 (viii) coating;
636 (ix) sterilizing; and
637 (x) filling sterile, aerosol, or gaseous drugs into dispensing containers.
638 (b) "Pharmaceutical manufacturing company" includes a brand name pharmaceutical
639 manufacturing company and a generic name manufacturing company, as defined in this section.
640 (8) "Pharmacy" means the same as that term is defined in Section 58-17b-102 and
641 includes all classes of pharmacies licensed under Title 58, Chapter 17b, Part 3, Licensing.
642 (9) "Pharmacy benefit manager" means the same as that term is defined in Section
643 49-20-502.

644 **26-18c-803. Tax.**

645 (1) In accordance with Part 19, Taxation and Collection, a tax is imposed on each
646 pharmaceutical manufacturer and pharmacy benefit manager based on gross receipts related to
647 outpatient prescription drugs services.

648 (2) In addition to the tax imposed in Subsection (1), each pharmacy benefit manager shall
649 pay an annual tax in the amount established in Subsection (4).

650 (3) Each pharmacy shall pay an annual tax in the amount established in Subsection (4).

651 (4) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each
652 pharmacy and pharmacy benefit manager shall pay a tax of \$206.

653 (b) For fiscal years beginning on or after July 1, 2018, each pharmacy and pharmacy
654 benefit manager shall pay a tax in the amount established under Part 20, UtahAccess+ Fund,
655 Taxes, and Annual Adjustment of Taxes.

656 **Part 9. Health Care Coverage Premium Tax**

657 **26-18c-901. Title.**

658 This part is known as "Health Care Coverage Premium Tax."

659 **26-18c-902. Definitions.**

660 As used in this part:

661 (1) "Accountable care organization" means a managed care organization, as defined in 42
662 C.F.R. Sec. 438, that contracts with the Department of Health under Section 26-18-405.

663 (2) (a) "Comprehensive health care coverage" means a policy or certificate that provides
664 benefits related to major medical expense insurance and includes:

665 (i) a health benefit plan;

666 (ii) an accountable care organization providing Medicaid benefits; and

667 (iii) insurance purchased by, or on behalf of, an employer for which the insurer assumes
668 all loss amounts of the employer's health benefit plan in excess of a stated amount, subject to the
669 policy limits.

670 (b) "Comprehensive health care coverage" does not include accident and health
671 insurance, as defined in Section 31A-1-301, that provides benefits solely for:

672 (i) dental;

673 (ii) vision;

674 (iii) income replacement;

675 (iv) accident;

676 (v) fixed indemnity;

677 (vi) long-term care insurance;

678 (vii) specified disease;

679 (viii) a Medicare plan or supplement;

680 (ix) federal employees health benefits;

681 (x) credit accident and health;

682 (xi) supplement to liability;

683 (xii) workers' compensation;

684 (xiii) automobile medical payment;

685 (xiv) no-fault automobile;

686 (xv) equivalent self-insurance;

687 (xvi) Children's Health Insurance Program created in Chapter 40, Utah Children's Health

688 Insurance Program Act; or
689 (xvii) a type of accident and health insurance coverage that is a part of or attached to
690 another type of policy.

691 (3) "Individual comprehensive health care coverage insurer" means an insurer that
692 provides coverage on an individual basis through comprehensive health care coverage.

693 (4) "Medical stop-loss insurance" means insurance purchased by, or on behalf of, an
694 employer under which the insurer assumes all loss amounts of the employer's health benefit plan
695 in excess of a stated amount, subject to the policy limits.

696 (5) "Medical stop-loss insurer" means an insurer that issues medical stop-loss insurance.

697 **26-18c-903. Calculation of tax.**

698 (1) In addition to any tax imposed under Section 59-9-101 for which the person is not
699 excluded under Subsection 59-9-101(5) and notwithstanding Section 59-9-103, an insurer shall
700 pay the following premium taxes:

701 (a) an individual comprehensive health care coverage insurer shall pay to the State Tax
702 Commission:

703 (i) on or before March 31, 2017 a tax of 0.8% of the total premiums received by it during
704 calendar year 2016 from comprehensive health care coverage issued in the state;

705 (ii) on or before March 31, 2018 a tax of 0.6% of the total premiums received by it
706 during calendar year 2017 from comprehensive health care coverage issued in the state; and

707 (iii) for calendar years beginning on or after January 1, 2018, a tax that is the amount
708 established under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes;

709 (b) a medical stop loss insurer shall pay to the State Tax Commission:

710 (i) on or before March 31, 2017 a tax of 0.38% of the total premiums received by it
711 during calendar year 2016 from medical stop-loss insurance issued in the state;

712 (ii) on or before March 31, 2018 a tax of 0.25% of the total premiums received by it
713 during calendar year 2017 from comprehensive health care coverage issued in the state; and

714 (iii) for calendar years beginning on or after January 1, 2018, the tax that is the amount
715 established under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes; and

716 (c) for an insurer issuing comprehensive health care coverage in this state that is not
717 described in Subsection (1)(a) or (b), the insurer shall pay to the State Tax Commission:

718 (i) on or before March 31, 2017, a tax of 0.035% of the total premiums received by it
719 during calendar year 2016 from comprehensive health care coverage issued in the state;

720 (ii) on or before March 31, 2018 a tax of 0.02% of the total premiums received by it
721 during calendar year 2017 from comprehensive health care coverage issued in the state; and

722 (iii) for calendar years beginning on or after January 1, 2018, a tax that is the amount
723 established under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

724 (2) An insurer issuing multiple policies to an insured may not artificially allocate the
725 premiums among the policies for purposes of reducing the aggregate premium tax applicable to
726 the policies.

727 (3) The retaliatory provisions of Title 31A, Chapter 3, Department Funding, Fees, and
728 Taxes, apply to the tax imposed under this part.

729 **Part 10. Ambulatory Surgical Center Services.**

730 **26-18c-1001. Title.**

731 This part is known as "Ambulatory Surgical Center Services."

732 **26-18c-1002. Definitions.**

733 As used in this part:

734 (1) "Ambulatory surgical facility" means a freestanding facility that provides services to
735 patients not requiring hospitalization.

736 (2) "Freestanding" means existing independently or physically separated from another
737 health care facility, as defined in Section 26-21-2, by fire walls and doors and administrated by
738 separate staff with separate records.

739 (3) "Ambulatory surgical services" means a facility service that does not include surgical
740 procedures.

741 **26-18c-1003. Tax.**

742 In accordance with Part 19, Taxation and Collection, a tax is imposed on each ambulatory
743 surgical facility based on the ambulatory surgical facility's gross receipts related to ambulatory
744 surgical services.

745 **Part 11. Dental Services.**

746 **26-18c-1101. Title.**

747 This part is known as "Dental Services."

748 **26-18c-1102. Definitions.**

749 As used in this part:

750 (1) "Dentist" means an individual licensed as a dentist under Title 58, Chapter 69,
751 Dentist and Dental Hygienist Practice Act.

752 (2) "Dentist" does not include a health care practitioner licensed under Title 58, Chapter
753 81, Retired Volunteer Health Care Practitioner Act.

754 **26-18c-1103. Tax.**

755 (1) Each year, there is levied a tax on a dentist, payable at the time the dentist's license is
756 issued or renewed.

757 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each
758 dentist shall pay a tax of \$0 per fiscal year.

759 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
760 under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

761 **Part 12. Podiatric Services.**

762 **26-18c-1201. Title.**

763 This part is known as "Podiatric Services."

764 **26-18c-1202. Definitions.**

765 As used in this part:

766 (1) "Podiatric physician" means an individual licensed under Title 58, Chapter 5a,
767 Podiatric Physician Licensing Act.

768 (2) "Podiatric physician" does not include a health care practitioner licensed under Title
769 58, Chapter 81, Retired Volunteer Health Care Practitioner Act.

770 **26-18c-1203. Tax.**

771 (1) Each year, there is levied a tax on each podiatric physician, payable at the time the
772 podiatric physician's license is issued or renewed.

773 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each

774 podiatric physician shall pay a tax of \$593 per fiscal year.

775 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
776 under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

777 **Part 13. Chiropractic Services.**

778 **26-18c-1301. Title.**

779 This part is known as "Chiropractic Services."

780 **26-18c-1302. Definitions.**

781 As used in this part, "chiropractic physician" means an individual licensed under Title 58,
782 Chapter 73, Chiropractic Physician Practice Act.

783 **26-18c-1303. Tax.**

784 (1) Each year, there is levied a tax on each chiropractic physician, payable at the time the
785 chiropractic physician's license is issued or renewed.

786 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each
787 chiropractic physician shall pay a tax of \$97 per fiscal year.

788 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
789 under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

790 **Part 14. Optometric Services.**

791 **26-18c-1401. Title.**

792 This part is known as "Optometric Services."

793 **26-18c-1402. Definitions.**

794 As used in this part:

795 (1) "Optometrist" means an individual licensed under Title 58, Chapter 16A, Utah
796 Optometry Practice Act.

797 (2) "Optometrist" does not include a health care practitioner licensed under Title 58,
798 Chapter 81, Retired Volunteer Health Care Practitioner Act.

799 **26-18c-1403. Tax.**

800 (1) Each year, there is levied a tax on each optometrist, payable at the time the
801 optometrist's license is issued or renewed.

802 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each
803 optometrist shall pay a tax of \$244 per fiscal year.

804 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
805 under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

806 **Part 15. Psychological Services.**

807 **26-18c-1501. Title.**

808 This part is known as "Psychological Services."

809 **26-18c-1502. Definitions.**

810 As used in this part:

811 (1) "Certified social worker" means an individual licensed as a certified social worker
812 under Section 58-60-204.

813 (2) "Clinical mental health counselor" means an individual licensed as a clinical mental
814 health counselor under Section 58-60-404.

815 (3) "Clinical social worker" means an individual licensed as a clinical social worker
816 under Section 58-60-204.

817 (4) "Marriage and family therapist" means an individual licensed as a marriage and
818 family therapist under Section 58-60-304.

819 (5) "Psychological facility" means a facility that:

820 (a) is not owned or operated by local government, state government or federal
821 government; and

822 (b) is one of the following, as defined by Section 62-2-101:

823 (i) day treatment;

824 (ii) outpatient treatment;

825 (iii) recovery residence;

826 (iv) residential support;

827 (v) residential treatment;

828 (vi) social detoxification.

829 (6) "Psychological services" means all services performed by an individual licensed as a
830 psychological services provider.

831 (7) "Psychological services provider" means a certified social worker, clinical mental
832 health counselor, clinical social worker, marriage and family therapist, psychologist, or
833 psychological facility.

834 (8) "Psychologist" means an individual licensed as a psychologist under Section
835 58-61-301.

836 **26-18c-1503. Tax.**

837 (1) Each year, a psychological services provider shall pay:

838 (a) the tax described in Subsection (2); and

839 (b) the tax described in Part 19, Taxation and Collection, on gross receipts related to
840 psychological services provided.

841 (2) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a
842 psychological services provider shall pay a tax of \$50.

843 (b) For fiscal years beginning on or after July 1, 2018, a psychological services provider
844 shall pay a tax in the amount established under Part 20, UtahAccess+ Fund, Taxes, and Annual
845 Adjustment of Taxes.

846 **Part 16. Therapist Services.**

847 **26-18c-1601. Title.**

848 This part is known as "Therapist Services."

849 **26-18c-1602. Definitions.**

850 As used in this part:

851 (1) (a) "Therapist services provider" means:

852 (i) an audiologist,

853 (ii) an occupational therapist;

854 (iii) a physical therapist;

855 (iv) a respiratory care practitioner; or

856 (v) a speech language pathologist.

857 (b) "Therapist services provider" does not include a health care practitioner licensed
858 under Title 58, Chapter 81, Retired Volunteer Health Care Practitioner Act.

859 (2) "Audiologist" means an individual licensed as an audiologist under Title 58, Chapter

860 41, Speech-Language Pathology and Audiology Licensing Act.

861 (3) "Occupational therapist" means an individual licensed as an occupational therapist
862 under Title 58, Chapter 42A, Occupational Therapy Practice Act.

863 (4) "Physical therapist" means an individual licensed as a physical therapist under Title
864 58, Chapter 24b, Physical Therapy Practice Act.

865 (5) "Respiratory care practitioner" means an individual licensed under Title 58, Chapter
866 57, Respiratory Care Practices Act.

867 (6) "Speech language pathologist" means an individual licensed as a speech language
868 pathologist under Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing
869 Act.

870 **26-18c-1603. Tax.**

871 (1) Each year, there is levied a tax on each therapist services provider, payable at the time
872 the therapist services provider's license is issued or renewed.

873 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, each
874 therapist services provider shall pay a tax of \$31 per fiscal year.

875 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
876 under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

877 **Part 17. Nursing Services**

878 **26-18c-1701. Title.**

879 This part is known as "Nursing Services."

880 **26-18c-1702. Definitions.**

881 As used in this part:

882 (1) "Advanced practice registered nurse" means an individual licensed as an advanced
883 practice registered nurse under Title 58, Chapter 31b, Nurse Practice Act.

884 (2) "Certified registered nurse anesthetist" means an individual licensed as a certified
885 registered nurse anesthetis under Title 58, Chapter 31b, Nurse Practice Act.

886 (3) "Certified nurse midwife" means an individual licensed as a certified nurse midwife
887 under Title 58, Chapter 44a, Nurse Midwife Practice Act.

888 (4) "Licensed practical nurse" means an individual licensed as a licensed practical nurse
889 under Title 58, Chapter 31b, Nurse Practice Act.

890 (5) "Nursing services provider" means an advanced practice registered nurse, a certified
891 registered nurse anesthetist, a certified nurse midwife, a licensed practical nurse, and a registered
892 nurse.

893 (7) "Registered nurse" means an individual licensed as a registered nurse under Title 58,
894 Chapter 31b, Nurse Practice Act.

895 (8) (a) "Services" means all services performed by an individual licensed as a nursing
896 services provider.

897 (b) "Services" does not include a nurse described in Subsections (1) through (7) who is
898 licensed under Title 58, Chapter 81, Retired Volunteer Health Care Practitioner Act.

899 **26-18c-1703. Tax.**

900 (1) Each year, a tax is imposed on each nursing services provider.

901 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, the
902 annual tax is \$3.

903 (3) For fiscal years beginning on or after July 1, 2018, the annual tax is the amount
904 established under Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

905 **Part 18. Laboratory and X-Ray Services**

906 **26-18c-1801. Title.**

907 This part is known as "Laboratory and X-Ray Services."

908 **26-18c-1802. Definitions.**

909 As used in the part:

910 (1) "Clinical laboratory" means a facility that:

911 (a) is freestanding; and

912 (b) performs clinical laboratory services.

913 (2) "Clinical laboratory services" means the biological, microbiological, serological,
914 chemical, immunohematological, hematological, biophysical, cytological, pathological, or other
915 examination of materials derived from the human body for the purpose of providing information
916 for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of
917 the health of, humans.

918 (3) "Freestanding" means existing independently or physically separated from another
919 health care facility, as defined in Section 26-21-2, by fire walls and doors and administered by
920 separate staff with separate records.

921 (4) "Laboratory and x-ray services" means:

922 (a) clinical laboratory services; or

923 (b) x-ray services

924 (5) "Laboratory and x-ray services provider" means:

925 (a) a clinical laboratory; or

926 (b) an x-ray service provider.

927 (6) "Radiology equipment" means any medical radiation device that emits ionizing or
928 nonionizing radiation or detects that radiation for the purpose or intended purpose of:

929 (a) diagnosing disease or other medical conditions in humans; or

930 (b) treating, curing, mitigating, or preventing disease in humans.

931 (7) "X-ray services" means the use of radiation from a radioactive substance, radiology
932 equipment, or any other source, in amounts beyond normal background levels, for diagnostic or
933 therapeutic purposes on humans.

934 (8) "X-ray service provider" means a facility that:

935 (a) is freestanding; and

936 (b) performs x-ray services.

937 **26-18c-1803. Tax.**

938 In accordance with Part 19, Taxation and Collection, a tax is imposed on each laboratory
939 and x-ray services provider based on the laboratory and x-ray services provider's gross receipts
940 related to laboratory and x-ray services.

941 **Part 19. Taxation and Collection**

942 **26-18c-1901. Title.**

943 This part is known as "Taxation and Collection."

944 **26-18c-1902. Definitions.**

945 (1) As used in this part:

946 (a) "Apportioned gross receipts" means a service provider's gross receipts apportioned to
947 this state in accordance with Sections 26-18c-1908 through 26-18c-1914.

948 (b) "Commission" means the State Tax Commission.

949 (c) "Gross receipts" means all consideration, without any deductions, for services.

950 (d) "Service provider" means:

951 (i) a durable medical equipment provider as defined in Section 26-18c-702;

952 (ii) a home health services provider as defined in Section 26-18c-702;

953 (iii) a pharmaceutical manufacturing company as defined in Section 26-18c-802;

954 (iv) a pharmacy benefit manager as defined in Section 26-18c-802;

955 (v) an ambulatory surgical facility as defined in Section 26-18c-1002;

956 (vi) a psychological services provider as defined in Section 26-18c-1502; or

957 (vii) a laboratory and x-ray services provider as defined in Section 26-18c-1602.

958 (e) "Services" means:

959 (i) for a durable medical equipment provider, durable medical equipment services as
960 defined in Section 26-18c-702;

961 (ii) for a home health services provider, home health services as defined in Section
962 26-18c-702;

963 (iii) for a pharmaceutical manufacturing company or pharmacy benefit manager,
964 outpatient prescription drug services as defined in Section 26-18c-802;

965 (iv) for an ambulatory surgical facility, ambulatory surgical services as defined in Section
966 26-18c-1001;

967 (v) for a psychological services provider, psychological services as defined in Section
968 26-18c-1502; or

969 (vi) for a laboratory and x-ray services provider, laboratory and x-ray services as defined
970 in Section 26-18c-1602.

971 **26-18c-1903. Tax imposed.**

972 (1) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
973 is imposed on each durable medical equipment provider determined by multiplying 0.0131% by
974 the apportioned gross receipts of the durable medical equipment provider for the calendar
975 quarter.

976 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
977 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

978 (2) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
979 is imposed on each home health services provider determined by multiplying 0.0131% by the
980 gross receipts of the home health services provider for the calendar quarter.

981 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
982 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

983 (3) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
984 is imposed on each pharmaceutical manufacturing company determined by multiplying 0.015%
985 by the apportioned gross receipts of the pharmaceutical manufacturing company for the calendar
986 quarter.

987 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
988 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

989 (4) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
990 is imposed on a pharmacy benefit manager determined by multiplying .015% by the gross
991 receipts of the pharmacy benefit manager for the calendar quarter.

992 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
993 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

994 (5) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
995 is imposed on each ambulatory surgical facility determined by multiplying 0.10% by the gross
996 receipts of the ambulatory surgical facility for the calendar quarter.

997 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
998 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

999 (6) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
1000 is imposed on each psychological services provider determined by multiplying 0.26% by the
1001 gross receipts of the psychological services provider for the calendar quarter.

1002 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
1003 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

1004 (7) (a) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, a tax
1005 is imposed on each laboratory and x-ray services provider determined by multiplying 0.05% by
1006 the gross receipts of the laboratory and x-ray services provider for the calendar quarter.

1007 (b) For fiscal years beginning on or after July 1, 2018, the tax is calculated in accordance
1008 with Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes.

1009 **26-18c-1904. Administration of tax.**

1010 The commission shall administer this part in accordance with Title 59, Chapter 1, General
1011 Taxation Policies.

1012 **26-18c-1905. Payment of tax -- Return filing requirements.**

1013 (1) A service provider shall file a return with the commission and pay the tax calculated
1014 on the return to the commission quarterly on or before the last day of the month immediately
1015 following the last day of the previous calendar quarter.

1016 (2) A service provider shall file the return in an electronic format approved by the
1017 commission.

1018 **26-18c-1906. Deposit of revenue.**

1019 The commission shall deposit revenue collected from a tax under this part into the
1020 UtahAccess+ Fund created by Section 26-18c-2003.

1021 **26-18c-1907. Penalties and interest.**

1022 A service provider that fails to comply with this part is subject to:

1023 (1) penalties provided in Section 59-1-401; and

1024 (2) interest provided in Section 59-1-402.

1025 **26-18c-1908. Application of apportionment.**

1026 The provisions of Sections 26-18c-1909 through 26-18c-1914 apply only to a durable
1027 medical equipment provider and a pharmaceutical manufacturing company.

1028 **26-18c-1909. Apportionment of gross receipts.**

1029 (1) A service provider that has gross receipts from business activity that is taxable both
1030 within and without this state shall calculate apportioned gross receipts in accordance with
1031 Sections 26-18c-1910 through 26-18c-1914.

1032 (2) A service provider that has gross receipts solely from business activity taxable within
1033 this state shall allocate or apportion its entire gross receipts to this state.

1034 **26-18c-1910. Method of apportionment of gross receipts.**

1035 A service provider shall calculate the fraction for apportioning gross receipts to this state
1036 as follows:

1037 (1) the numerator of the fraction is the sales factor as calculated under Section
1038 26-18c-1911; and

1039 (2) the denominator of the fraction is one.

1040 **26-18c-1911. Sales factor for apportionment of gross receipts.**

1041 The sales factor is a fraction, the numerator of which is the total gross receipts of the
1042 service provider in this state during the calendar quarter, and the denominator of which is the
1043 total gross receipts of the service provider everywhere during the calendar quarter.

1044 **26-18c-1912. Sales of tangible personal property.**

1045 Gross receipts from sales of tangible personal property are in this state if:

1046 (1) the property is delivered or shipped to a purchaser, other than the United States
1047 Government, within the state regardless of the f.o.b. point or other conditions of the sale; or

1048 (2) (a) the property is shipped from an office, store, warehouse, factory, or other place of
1049 storage in this state; and

1050 (b) (i) the purchaser is the United States Government; or

1051 (ii) the service provider is not taxable in the state of the purchaser.

1052 **26-18c-1913. Circumstances under which rents or other income is considered to be**
1053 **in this state.**

1054 The following from gross receipts are considered to be in this state:

1055 (1) a rent in connection with tangible personal property if the tangible personal property
1056 is in this state; or

1057 (2) other income in connection with tangible personal property if the tangible personal
1058 property is in this state.

1059 **26-18c-1914. Equitable adjustment of allocation or apportionment.**

1060 Notwithstanding any other provisions of this part, if the allocation and apportionment
1061 provisions of this part do not fairly represent the extent of a service provider's business activity in
1062 this state, the service provider may petition for or the commission may require, with respect to all
1063 or any part of the service provider's business activity, if reasonable:

1064 (1) separate accounting;

1065 (2) the inclusion of one or more additional factors that will fairly represent the service
1066 provider's business activity in this state; or

1067 (3) the employment of any other method to effectuate an equitable allocation and
1068 apportionment of the service provider's gross receipts.

1069 **Part 20. UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes**

1070 **26-18c-2001. Title.**

1071 This part is known as "UtahAccess+ Fund, Taxes, and Annual Adjustment of Taxes."

1072 **26-18c-2002. Definitions.**

1073 As used in this part,

1074 (1) "Adults who were previously eligible but not enrolled" means, as determined by the

1075 department, adults enrolled in the Medicaid program during a fiscal year, but not under this
1076 chapter, whose enrollment is attributable to the implementation of UtahAccess+.
1077 (2) "Insurer class" means the following three classes:
1078 (a) individual comprehensive health care coverage insurers taxed under Section
1079 26-18c-903(1)(a);
1080 (b) medical stop loss insurers taxed under Section 26-18c-903(1)(b); and
1081 (c) insurers issuing comprehensive health care coverage in this state that is not described
1082 in Subsections 26-18c-903(a) or (b), which are taxed under Section 26-18c-903(1)(c).
1083 (3) "Insurer class factor" means the amount calculated by dividing insurer class payments
1084 by total Utah Access+ insurer payments.
1085 (4) "Insurer class payments" means total payments made by the Medicaid program to an
1086 insurer class during the second preceding fiscal year to fund:
1087 (a) AccessUtah+; and
1088 (b) Medicaid program services and benefits to adults who were previously eligible but
1089 not enrolled.
1090 (5) "Medical provider class" means the following 16 classes:
1091 (a) persons assessed under Part 4, Inpatient Hospital Services;
1092 (b) persons assessed under Part 5, Outpatient Hospital Services;
1093 (c) persons assessed under Part 6, Physician Services;
1094 (d) persons assessed under Part 7, Home Health Care Services;
1095 (e) persons assessed under Part 8, Outpatient Prescription Drugs;
1096 (f) persons assessed under Part 9, Managed Care Organizations;
1097 (g) persons assessed under Part 10, Ambulatory Surgical Center Services;
1098 (h) persons assessed under Part 11, Dental Services;
1099 (i) persons assessed under Part 12, Podiatric Services;
1100 (j) persons assessed under Part 13, Chiropractic Services;
1101 (k) persons assessed under Part 14, Optometric Services;
1102 (l) persons assessed under Part 15, Psychological Services;
1103 (m) persons assessed under Part 16, Therapist Services;
1104 (n) persons assessed under Part 17, Nursing Services;
1105 (o) persons assessed under Part 18, Laboratory and X-Ray Services; and
1106 (p) emergency ambulance service providers assessed under Section 26-37a-105.1;
1107 (6) "Medical provider class factor" means the amount calculated by dividing medical
1108 provider class payments by total payments for UtahAccess+.
1109 (7) "Medical provider class payments" means total payments made by the Medicaid
1110 program to a medical provider class during the second preceding fiscal year to fund:
1111 (a) AccessUtah+; and
1112 (b) Medicaid program services and benefits to adults who were previously eligible but
1113 not enrolled.
1114 (8) "Ongoing General Fund savings" means the sum of the following savings:
1115 (a) 13,000,000 ongoing General Fund savings to the Division of Substance Abuse and
1116 Mental Health within the Department of Human Services, which is attributable to the
1117 implementation of AccessUtah+;

1118 (b) \$1,700,000 ongoing General Fund savings, which is attributable to 2015 General
1119 Session H.B. 348, Criminal Justice Programs and Amendments; and
1120 (c) preferred drug list savings for the immediately preceding fiscal year appropriated to
1121 the UtahAccess+ Fund under Subsection 26-18-2.4(4).
1122 (9) "Outpatient prescription drugs provider class" means the following three classes:
1123 (a) brand name pharmaceutical manufacturing companies taxed under Section
1124 26-18c-1903(3);
1125 (b) generic name pharmaceutical manufacturing companies taxed under Section
1126 26-18c-1903(4); and
1127 (c) pharmaceutical benefit managers taxed under Section 26-18c-1903(5).
1128 (10) "Outpatient prescription drugs provider class factor" means the amount calculated
1129 by dividing outpatient prescription drugs provider class payments by total Utah Access+
1130 payments for outpatient prescription drugs.
1131 (11) "Outpatient prescription drugs provider class payments" means total payments made
1132 by the Medicaid program to an outpatient prescription drugs provider class during the second
1133 preceding fiscal year to fund:
1134 (a) AccessUtah+; and
1135 (b) Medicaid program services and benefits to adults who were previously eligible but
1136 not enrolled.
1137 (12) "Preferred drug list savings" means the amount appropriated to the UtahAccess+
1138 Fund under Subsection 26-18-2.4(4).
1139 (13) "Projected total expenditures" means expenditures projected for a fiscal year by all
1140 state agencies administering the provisions of this chapter as determined via consensus by the
1141 Office of the Legislative Fiscal Analyst, Governor's Office of Planning and Budget, and the
1142 Department of Health.
1143 (14) "Proportionate share of funding for insurers" means the amount calculated by
1144 multiplying the total assessment target by:
1145 (a) 0.10; and
1146 (b) the insurer class factor for the insurer class.
1147 (15) "Proportionate share of funding for outpatient prescription drugs providers" means
1148 the amount calculated by
1149 (16) "Proportionate share of total funding for the medical provider class" means the
1150 amount calculated by multiplying the total assessment target by:
1151 (a) 0.90; and
1152 (b) the medical provider class factor for the class.
1153 (17) "State cost of UtahAccess+" means the amount calculated by multiplying 0.10 by
1154 the projected service total expenditures necessary to fund UtahAccess+ during a fiscal year.
1155 (18) "Total tax target" means the amount calculated by making the following adjustments
1156 to the state cost of UtahAccess+:
1157 (a) adding the cost of providing Medicaid program services and benefits to adults who
1158 were previously eligible but not enrolled; and
1159 (b) subtracting ongoing General Fund savings.
1160 (19) "Total UtahAccess+ insurer payments" means total payments made by the Medicaid

1161 program to an insurer class during the second preceding fiscal year to fund:
1162 (a) AccessUtah+; and
1163 (b) Medicaid program services and benefits to adults who were previously eligible but
1164 not enrolled.
1165 (20) "Total UtahAccess+ payments for outpatient prescription drugs" means total
1166 payments made by the Medicaid program to an outpatient prescription drugs provider class
1167 during the second preceding fiscal year to fund:
1168 (a) AccessUtah+; and
1169 (b) Medicaid program services and benefits to adults who were previously eligible but
1170 not enrolled.
1171 (21) "Total payments for UtahAccess+" means the sum of all medical provider class
1172 payments.
1173 **26-18c-2003. UtahAccess+ Fund.**
1174 (1) There is created an expendable special revenue fund known as the UtahAccess+
1175 Fund.
1176 (2) The fund consists of:
1177 (a) taxes and assessments collected under Parts 4 through 19 and Section 26-37a-105.1;
1178 (b) savings attributable to UtahAccess+;
1179 (c) preferred drug list savings appropriated to the fund under Subsection 26-18-2.4(4);
1180 (d) gifts, grants, donations, or any other conveyance of money that may be made to the
1181 fund from private sources; and
1182 (e) additional amounts as appropriated by the Legislature.
1183 (3) (a) The fund shall earn interest.
1184 (b) All interest earned on fund money shall be deposited into the fund.
1185 (4) (a) A state agency administering the provisions of this chapter may use money from
1186 the fund to pay the costs of administering UtahAccess+ not otherwise paid for with federal funds
1187 or other revenue sources.
1188 (b) Money in the fund may not be used for any other purpose.
1189 **26-18c-2004. Annual adjustment of assessments.**
1190 (1) For each fiscal year beginning on or after July 1, 2018, the taxes and assessments in
1191 Parts 4 through 19 of this chapter and Section 26-37a-105.1 shall be adjusted as follows:
1192 (a) the taxes in Part 9, Health Care Coverage Premium Tax, shall be adjusted so that:
1193 (i) the sum of taxes paid by insurers under the part during the fiscal year equals 10
1194 percent of the total tax target; and
1195 (ii) the sum of taxes paid by insurers within an insurer class equals the proportionate
1196 share of funding for insurers;
1197 (b) the taxes and assessments in Parts 4 through 8 of this chapter, Parts 10 through 19 of
1198 this chapter, and Section 26-37a-105.1 shall be adjusted so that:
1199 (i) the sum of taxes and assessments paid by providers within a medical provider class
1200 during the fiscal year equals the proportionate share of total funding for the medical provider
1201 class; and
1202 (ii) (A) the sum of taxes and assessments paid by outpatient prescription drugs providers
1203 within an outpatient prescription drugs provider class equals the proportionate share of funding

1204 for outpatient prescription drugs providers;
1205 (B) the rate at which the gross receipts of a pharmacy benefit manager are taxed under
1206 Section 26-18c-1903(5) and the tax that a pharmacy benefit manager must pay under Section
1207 26-18c-803(4) are adjusted by the same percentage.

1208 (iii) the rate at which the gross receipts of a psychological services provider are taxed
1209 under Section 26-18c-1903(7) and the tax that a psychological services provider must pay under
1210 Section 26-18c-1503(2) are adjusted by the same percentage.

1211 (2) After the adjustments are made under Subsection (1), the rate at which the gross
1212 receipts of a brand name pharmaceutical manufacturing company are taxed under Section
1213 26-18c-1903(3) and the tax that brand name pharmaceutical manufacturing company must pay
1214 under Section 26-18c-803(4) shall be reduced by an equal percentage so that the sum of taxes
1215 paid by brand name pharmaceutical manufacturing companies under the two sections during the
1216 fiscal year is reduced by an amount equal to preferred drug list savings.

1217 (3) The adjusted taxes and assessments and the estimated sum of taxes and assessments
1218 to be paid by providers within each medical provider class, each insurer class, and each
1219 outpatient prescription drugs provider class shall be included in the annual appropriations act for
1220 the fiscal year.

1221 **26-18c-2005. Data collection.**

1222 (1) For fiscal years beginning on or after July 1, 2016, the department shall collect and
1223 report to the Legislature the information necessary to calculate:

1224 (a) for each medical provider class, the proportionate share of total funding for the
1225 medical provider class;

1226 (b) for each insurer class, the proportionate share of funding for insurers; and

1227 (c) for each outpatient prescription drugs provider class, the proportionate share of
1228 funding for outpatient prescription drugs providers.

1229 (2) The department shall require Medicaid contractors serving the adult expansion
1230 population to provide enough information to accomplish the duties set forth for the department in
1231 this section.

1232 **26-37a-105.1. UtahAccess+ tax.**

1233 (1) In addition to the assessment described in Section 26-37a-103, each year, there is
1234 levied a tax on each ambulance service provider.

1235 (2) For fiscal years beginning on or after July 1, 2016, and before July 1, 2018, the tax is
1236 an amount equal to \$2.09 multiplied by the ambulance service provider's total transports.

1237 (3) For fiscal years beginning on or after July 1, 2018, the tax is the amount established
1238 under Title 26, Chapter 18c, Part 20, UtahAccess+ Fund, Taxes, and Annual Adjustment of
1239 Taxes.

1240