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H.B. 437

1 # HEALTH CARE REVISIONS

2 2016 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

9 This bill implements a health coverage improvement program through Medicaid waiver
10 authority granted to states before the federal Patient Protection and Affordable Care
11 Act, and establishes a funding mechanism for the waiver program.

12 **Highlighted Provisions:**

13 This bill:

14 ▸ authorizes a preferred drug list for psychotropic drugs with an override for dispense
15 as written;

16 ▸ establishes targets for provider compliance with the preferred drug list;

17 ▸ authorizes the Department of Health to apply for waivers from federal law necessary
18 to implement a health coverage improvement program in Medicaid;

19 ▸ defines terms;

20 ▸ describes the Medicaid waiver request;

21 ▸ permits a waiver enrollee to maintain Medicaid coverage for 12 months;

22 ▸ provides eligibility criteria;

23 ▸ amends the county matching funds for enrollees in the health coverage improvement
24 program;

25 ▸ expands Medicaid eligibility for adults with dependent children;

26 ▸ requires the Department of Health to apply for a waiver for the existing Medicaid
27 population and the enrollees in the health coverage improvement program to allow

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28 residential treatment services at facilities with no bed capacity limits;
29 ▸ enhances the efficiency of Medicaid enrollment for adults released from
30 incarceration;
31 ▸ establishes an inpatient hospital assessment to fund the Medicaid waiver;
32 ▸ authorizes the Public Employees' Benefit and Insurance Program to provide services
33 for drugs and devices for certain individuals at the request of a procurement unit;
34 and
35 ▸ requires the Department of Health to study methods to increase coverage to
36 uninsured low income adults with children and to maximize the use of employer
37 sponsored coverage.
38 **Money Appropriated in this Bill:**
39 None
40 **Other Special Clauses:**
41 None
42 **Utah Code Sections Affected:**
43 AMENDS:
44 **26-18-2.4**, as last amended by Laws of Utah 2012, Chapters 242 and 343
45 **26-18-18**, as last amended by Laws of Utah 2015, Chapter 283
46 **49-20-401**, as last amended by Laws of Utah 2015, Chapter 155
47 **63I-1-226**, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258
48 ENACTS:
49 **26-18-411**, Utah Code Annotated 1953
50 **26-36b-101**, Utah Code Annotated 1953
51 **26-36b-102**, Utah Code Annotated 1953
52 **26-36b-103**, Utah Code Annotated 1953
53 **26-36b-201**, Utah Code Annotated 1953
54 **26-36b-202**, Utah Code Annotated 1953
55 **26-36b-203**, Utah Code Annotated 1953
56 **26-36b-204**, Utah Code Annotated 1953
57 **26-36b-205**, Utah Code Annotated 1953
58 **26-36b-206**, Utah Code Annotated 1953

59 **26-36b-207**, Utah Code Annotated 1953
60 **26-36b-208**, Utah Code Annotated 1953
61 **26-36b-209**, Utah Code Annotated 1953
62 **26-36b-210**, Utah Code Annotated 1953
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64 *Be it enacted by the Legislature of the state of Utah:*
65 Section 1. Section **26-18-2.4** is amended to read:
66 **26-18-2.4. Medicaid drug program -- Preferred drug list.**
67 (1) A Medicaid drug program developed by the department under Subsection
68 26-18-2.3(2)(f):
69 (a) shall, notwithstanding Subsection 26-18-2.3(1)(b), be based on clinical and
70 cost-related factors which include medical necessity as determined by a provider in accordance
71 with administrative rules established by the Drug Utilization Review Board;
72 (b) may include therapeutic categories of drugs that may be exempted from the drug
73 program;
74 (c) may include placing some drugs, except the drugs described in Subsection (2), on a
75 preferred drug list:
76 (i) to the extent determined appropriate by the department; and
77 (ii) in the manner described in Subsection (3) for psychotropic drugs;
78 (d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and
79 except as provided in Subsection (3), shall immediately implement the prior authorization
80 requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:
81 (i) on the preferred drug list on the date that this act takes effect; or
82 (ii) added to the preferred drug list after this act takes effect; and
83 (e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior
84 authorization requirements established under Subsections (1)(c) and (d) which shall permit a
85 health care provider or the health care provider's agent to obtain a prior authorization override
86 of the preferred drug list through the department's pharmacy prior authorization review process,
87 and which shall:
88 (i) provide either telephone or fax approval or denial of the request within 24 hours of
89 the receipt of a request that is submitted during normal business hours of Monday through

90 Friday from 8 a.m. to 5 p.m.;
91 (ii) provide for the dispensing of a limited supply of a requested drug as determined
92 appropriate by the department in an emergency situation, if the request for an override is
93 received outside of the department's normal business hours; and
94 (iii) require the health care provider to provide the department with documentation of
95 the medical need for the preferred drug list override in accordance with criteria established by
96 the department in consultation with the Pharmacy and Therapeutics Committee.
97 (2) (a) For purposes of this Subsection (2):
98 (i) "Immunosuppressive drug":
99 (A) means a drug that is used in immunosuppressive therapy to inhibit or prevent
100 activity of the immune system to aid the body in preventing the rejection of transplanted organs
101 and tissue; and
102 (B) does not include drugs used for the treatment of autoimmune disease or diseases
103 that are most likely of autoimmune origin.
104 [~~(ii) "Psychotropic drug" means the following classes of drugs: atypical anti-psychotic,~~
105 ~~anti-depressants, anti-convulsant/mood stabilizer, anti-anxiety, attention deficit hyperactivity~~
106 ~~disorder stimulants, or sedative/hypnotics.~~]
107 [~~(iii)~~] (ii) "Stabilized" means a health care provider has documented in the patient's
108 medical chart that a patient has achieved a stable or steadfast medical state within the past 90
109 days using a particular psychotropic drug.
110 (b) A preferred drug list developed under the provisions of this section may not
111 include[~~: (i) except as provided in Subsection (2)(e), a psychotropic or anti-psychotic drug; or~~
112 ~~(ii)~~] an immunosuppressive drug.
113 (c) The state Medicaid program shall reimburse for a prescription for an
114 immunosuppressive drug as written by the health care provider for a patient who has undergone
115 an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to patients
116 who have undergone an organ transplant, the prescription for a particular immunosuppressive
117 drug as written by a health care provider meets the criteria of demonstrating to the Department
118 of Health a medical necessity for dispensing the prescribed immunosuppressive drug.
119 (d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the
120 state Medicaid drug program may not require the use of step therapy for immunosuppressive

121 drugs without the written or oral consent of the health care provider and the patient.
122 (e) The department may include a sedative hypnotic on a preferred drug list in
123 accordance with Subsection (2)(f).
124 (f) The department shall grant a prior authorization for a sedative hypnotic that is not
125 on the preferred drug list under Subsection (2)(e), if the health care provider has documentation
126 related to one of the following conditions for the Medicaid client:
127 (i) a trial and failure of at least one preferred agent in the drug class, including the
128 name of the preferred drug that was tried, the length of therapy, and the reason for the
129 discontinuation;
130 (ii) detailed evidence of a potential drug interaction between current medication and
131 the preferred drug;
132 (iii) detailed evidence of a condition or contraindication that prevents the use of the
133 preferred drug;
134 (iv) objective clinical evidence that a patient is at high risk of adverse events due to a
135 therapeutic interchange with a preferred drug;
136 (v) the patient is a new or previous Medicaid client with an existing diagnosis
137 previously stabilized with a nonpreferred drug; or
138 (vi) other valid reasons as determined by the department.
139 (g) A prior authorization granted under Subsection (2)(f) is valid for one year from the
140 date the department grants the prior authorization and shall be renewed in accordance with
141 Subsection (2)(f).
142 (3) (a) For purposes of this Subsection (3), "psychotropic drug" means the following
143 classes of drugs:
144 (i) atypical anti-psychotic;
145 (ii) anti-depressant;
146 (iii) anti-convulsant/mood stabilizer;
147 (iv) anti-anxiety; and
148 (v) attention deficit hyperactivity disorder stimulant.
149 (b) The department shall, by July 1, 2016, develop a preferred drug list for
150 psychotropic drugs. Except as provided in Subsection (3)(d), a preferred drug list for
151 psychotropic drugs developed under this section shall allow a health care provider to override

152 the preferred drug list by writing "dispense as written" on the prescription for the psychotropic
153 drug.
154 (c) The department, and a Medicaid accountable care organization that is responsible
155 for providing behavioral health, shall:
156 (i) establish a system to:
157 (A) track health care provider prescribing patterns for psychotropic drugs;
158 (B) educate health care providers who are not complying with the preferred drug list;
159 and
160 (C) implement peer to peer education for health care providers whose prescribing
161 practices continue to not comply with the preferred drug list; and
162 (ii) determine whether health care provider compliance with the preferred drug list is at
163 least:
164 (A) 55% by July 1, 2017;
165 (B) 65% by July 1, 2018; and
166 (C) 75% by July 1, 2019.
167 (d) Beginning October 1, 2019, the department shall eliminate the dispense as written
168 override for the preferred drug list, and shall implement a prior authorization system for
169 psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019:
170 (i) health care provider compliance with the psychotropic drug preferred drug list is not
171 at least 75%; and
172 (ii) the department has not realized its projected savings from implementing the
173 preferred drug list for psychotropic drugs.
174 [(3)] (4) The department shall report to the Health and Human Services Interim
175 Committee and to the Social Services Appropriations Subcommittee [prior to] before
176 November 1, [2013] 2016, and before each November 30 thereafter, regarding:
177 (a) the savings to the Medicaid program resulting from the use of the preferred drug list
178 permitted by Subsection (1)[.]; and
179 (b) the compliance with and savings from the use of the preferred drug list for
180 psychotropic drugs under Subsection (3).
181 Section 2. Section **26-18-18** is amended to read:
182 **26-18-18. Optional Medicaid expansion.**

183 (1) For purposes of this section [PPACA is as], "PPACA" means the same as that term
184 is defined in Section 31A-1-301.
185 (2) The department and the governor shall not expand the state's Medicaid program to
186 the optional population under PPACA unless:
187 [(a) the Health Reform Task Force has completed a thorough analysis of a statewide
188 charity care system;]
189 [(b) the department and its contractors have:]
190 [(i) completed a thorough analysis of the impact to the state of expanding the state's
191 Medicaid program to optional populations under PPACA; and]
192 [(ii) made the analysis conducted under Subsection (2)(b)(i) available to the public;]
193 [(c)] (a) the governor or the governor's designee has reported the intention to expand
194 the state Medicaid program under PPACA to the Legislature in compliance with the legislative
195 review process in Sections 63N-11-106 and 26-18-3; and
196 [(d)] (b) (i) notwithstanding Subsection 63J-5-103(2), the governor submits the request
197 for expansion of the Medicaid program for optional populations to the Legislature under the
198 high impact federal funds request process required by Section 63J-5-204, Legislative review
199 and approval of certain federal funds request[.]; or
200 (ii) the department obtains approval from the Centers for Medicare and Medicaid
201 Services within the United States Department of Health and Human Services for waivers from
202 federal statutory and regulatory law necessary to implement the health coverage improvement
203 program under Section 26-18-411.
204 Section 3. Section **26-18-411** is enacted to read:
205 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
206 **-- Expansion of eligibility for adults with dependent children.**
207 (1) For purposes of this section:
208 (a) "Adult in the expansion population" means an individual who:
209 (i) is described in 42 U.S.C. Sec. 1396a(10)(A)(i)(VIII); and
210 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
211 individual.
212 (b) "CMS" means the Centers for Medicare and Medicaid Services within the United
213 States Department of Health and Human Services.

214 (c) "Federal poverty level" means the poverty guidelines established by the secretary of
215 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).
216 (d) "Homeless":
217 (i) means an individual who is chronically homeless, as determined by the department;
218 and
219 (ii) includes someone who was chronically homeless and is currently living in
220 supported housing for the chronically homeless.
221 (e) "Income eligibility ceiling" means the percent of federal poverty level:
222 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
223 Chapter 1, Budgetary Procedures Act; and
224 (ii) under which an individual may qualify for Medicaid coverage in accordance with
225 this section.
226 (2) (a) No later than July 1, 2016, the division shall submit to CMS a request for
227 waivers, or an amendment of existing waivers, from federal statutory and regulatory law
228 necessary for the state to implement the health coverage improvement program in the Medicaid
229 program in accordance with this section.
230 (b) An adult in the expansion population is eligible for Medicaid if the adult meets the
231 income eligibility and other criteria established under Subsection (3).
232 (c) An adult who qualifies under Subsection (3) shall receive Medicaid coverage:
233 (i) through:
234 (A) the traditional fee for service Medicaid model in counties without Medicaid
235 accountable care organizations or the state's Medicaid accountable care organization delivery
236 system, where implemented; and
237 (B) except as provided in Subsection (2)(c)(ii), for behavioral health, through the
238 counties in accordance with Sections 17-43-201 and 17-43-301;
239 (ii) that integrates behavioral health services and physical health services in selected
240 geographic areas of the state with Medicaid accountable care organizations; and
241 (iii) that permits residential treatment in a facility without a bed capacity limit, as
242 approved by CMS.
243 (d) Medicaid accountable care organizations and counties that integrate care under
244 Subsection (2)(c)(ii) shall collaborate on enrollment, engagement of patients, and coordination

245 of services.
246 (3) (a) An individual is eligible for the health coverage improvement program under
247 Subsection (2)(b) if:
248 (i) at the time of enrollment, the individual's annual income is below the income
249 eligibility ceiling established by the state under Subsection (1)(e); and
250 (ii) the individual meets the eligibility criteria established by the department under
251 Subsection (3)(b).
252 (b) Based on available funding and approval from CMS, the department shall select the
253 criteria for an individual to qualify for the Medicaid program under Subsection (3)(a)(ii), based
254 on the following priority:
255 (i) a chronically homeless individual;
256 (ii) an individual:
257 (A) involved in the justice system through probation, parole, or court ordered
258 treatment; and
259 (B) in need of substance abuse treatment or mental health treatment, as determined by
260 the department; or
261 (iii) an individual in need of substance abuse treatment or mental health treatment, as
262 determined by the department.
263 (c) An individual who qualifies for Medicaid coverage under Subsection (3)(a) and (b)
264 may remain on the Medicaid program for 12 months, and changes to eligibility criteria during
265 that 12-month period do not apply to that individual until the individual re-applies for the
266 Medicaid program at the end of the 12-month enrollment.
267 (4) The state may request a modification of the income eligibility ceiling and other
268 eligibility criteria under Subsection (3) each fiscal year based on enrollment in the health
269 coverage improvement program, projected enrollment, costs to the state, and the state budget.
270 (5) On or before September 30, 2017, and on or before September 30 each year
271 thereafter, the department shall report to the Legislature's Health and Human Services Interim
272 Committee and to the Legislature's Executive Appropriations Committee:
273 (a) the number of individuals who enrolled in Medicaid under Subsection (2);
274 (b) the state cost of providing Medicaid to individuals enrolled under Subsection (2);
275 and

276 (c) recommendations for adjusting the income eligibility ceiling under Subsection (4),
277 and other eligibility criteria under Subsection (3), for the upcoming fiscal year.
278 (6) In addition to the waiver under Subsection (2), beginning July 1, 2016, the
279 department shall amend the state Medicaid plan:
280 (a) for an individual without a dependent child, to increase the income eligibility
281 ceiling to a percent of the federal poverty level designated by the department, based on
282 appropriations for the program; and
283 (b) to allow residential treatment for the traditional current Medicaid population at
284 facilities with no bed capacity limits, as long as the county makes the match required under
285 Sections 17-43-201 and 17-43-301.
286 (7) The current Medicaid program and the health coverage improvement program,
287 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
288 enrollment for an individual who is released from custody and was eligible for or enrolled in
289 Medicaid before incarceration.
290 (8) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
291 provide matching funds to the state for the cost of providing Medicaid services to newly
292 enrolled individuals who qualify for Medicaid coverage under the health coverage
293 improvement program under Subsection (3).
294 (9) The department shall:
295 (a) study, in consultation with health care providers, employers, uninsured families,
296 and community stakeholders:
297 (i) options to maximize use of employer sponsored coverage for current Medicaid
298 enrollees; and
299 (ii) strategies to increase participation of currently Medicaid eligible, and uninsured,
300 children; and
301 (b) report the findings of the study to the Legislature's Health Reform Task Force
302 before November 30, 2016.
303 Section 4. Section **26-36b-101** is enacted to read:
304 **CHAPTER 36b. INPATIENT HOSPITAL ASSESSMENT ACT**
305 **Part 1. General Provisions**
306 **26-36b-101. Title.**

307 This chapter is known as "Inpatient Hospital Assessment Act."
308 Section 5. Section **26-36b-102** is enacted to read:
309 **26-36b-102. Application.**
310 (1) Other than for the imposition of the assessment described in this chapter, nothing in
311 this chapter shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious,
312 or educational health care provider under:
313 (a) Section 501(c), as amended, of the Internal Revenue Code;
314 (b) other applicable federal law;
315 (c) any state law;
316 (d) any ad valorem property taxes;
317 (e) any sales or use taxes; or
318 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed, by
319 the state or any political subdivision, county, municipality, district, authority, or any agency or
320 department thereof.
321 (2) All assessments paid under this chapter may be included as an allowable cost of a
322 hospital for purposes of any applicable Medicaid reimbursement formula.
323 (3) This chapter does not authorize a political subdivision of the state to:
324 (a) license a hospital for revenue;
325 (b) impose a tax or assessment upon a hospital; or
326 (c) impose a tax or assessment measured by the income or earnings of a hospital.
327 Section 6. Section **26-36b-103** is enacted to read:
328 **26-36b-103. Definitions.**
329 As used in this chapter:
330 (1) "Assessment" means the inpatient hospital assessment established by this chapter.
331 (2) "Discharges" means the number of total hospital discharges reported on:
332 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost
333 report for the applicable assessment year; or
334 (b) a similar report adopted by the department by administrative rule, if the report
335 under Subsection (2)(a) is no longer available.
336 (3) "Division" means the Division of Health Care Financing within the department.
337 (4) "Hospital":

338 (a) means:
339 (i) a privately owned general acute hospital operating in the state as defined in Section
340 26-21-2;
341 (ii) a privately owned specialty hospital operating in the state, which shall include a
342 privately owned hospital whose inpatient admissions are predominantly:
343 (A) rehabilitation;
344 (B) psychiatric;
345 (C) chemical dependency; or
346 (D) long-term acute care services;
347 (iii) a state owned teaching hospital that is part of an institution of higher education;
348 and
349 (iv) a hospital owned by a non-state government entity; and
350 (b) does not include:
351 (i) a residential care or treatment facility as defined in Section 62A-2-101;
352 (ii) a hospital owned by the federal government, including the Veterans Administration
353 Hospital; or
354 (iii) the Utah State Hospital.
355 (5) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of
356 hospitals.
357 Section 7. Section **26-36b-201** is enacted to read:
358 **Part 2. Assessment and Collection**
359 **26-36b-201. Assessment.**
360 (1) A uniform, broad based assessment is imposed on each hospital:
361 (a) beginning when the Centers for Medicare and Medicaid Services within the United
362 States Department of Health and Human Services approves:
363 (i) the health coverage improvement program waiver under Section 26-18-411; and
364 (ii) the assessment under this chapter;
365 (b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and
366 (c) in accordance with Section 26-36b-202.
367 (2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and
368 payable on a quarterly basis.

369 Section 8. Section **26-36b-202** is enacted to read:

370 **26-36b-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**

371 (1) The collecting agent for assessment imposed under Section 26-36b-201 is the
372 department. The department is vested with the administration and enforcement of this chapter,
373 including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah
374 Administrative Rulemaking Act, necessary to:

375 (a) implement and enforce the provisions of this chapter;

376 (b) audit records of a facility that:

377 (i) is subject to the assessment imposed by this chapter; and

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

379 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
380 Medicare cost report.

381 (2) The department shall:

382 (a) administer the assessment in this part separate from the assessment in Chapter 36a,
383 Hospital Provider Assessment Act; and

384 (b) deposit assessments collected under this chapter in the Medicaid Expansion Fund
385 created by Section 26-36b-207.

386 Section 9. Section **26-36b-203** is enacted to read:

387 **26-36b-203. Quarterly notice.**

388 Quarterly assessments imposed by this chapter shall be paid to the division within 15
389 business days after the original invoice date that appears on the invoice issued by the division.
390 The department may, by rule, extend the time for paying the assessment.

391 Section 10. Section **26-36b-204** is enacted to read:

392 **26-36b-204. Hospital financing of health coverage improvement program**
393 **Medicaid waiver -- Hospital share.**

394 (1) For purposes of this section, "hospital share":

395 (a) means the percent of the state's net cost of:

396 (i) the health coverage improvement program Medicaid waiver under Section
397 26-18-411;

398 (ii) Medicaid coverage for individuals with dependent children up to the percent of the
399 federal poverty level designated under Section 26-18-411; and

400 (iii) the outpatient UPL gap, as that term is defined in Section 26-36b-209;
401 (b) shall be capped at no more than $13,600,000 annually; and
402 (c) if the Medicaid program expands in a manner that is greater than the expansion
403 described in Section 26-18-411, is capped at 33% of the state's share of the cost of the
404 expansion that is in addition to the program described in Section 26-18-411.
405 (2) The hospital share under Subsection (1) shall be divided as follows:
406 (a) the state-owned teaching hospital is responsible for 30% of the hospital share;
407 (b) hospitals owned by a non-state government entity are responsible for 1% of the
408 hospital share; and
409 (c) other hospitals are responsible for 69% of the hospital share.
410 (3) (a) The department shall, on or before October 15, 2017, and on or before October
411 15 of each year thereafter, produce a report that calculates the state's net cost of the programs
412 described in Subsections (1)(a)(i) and (ii).
413 (b) If the assessment collected in the previous fiscal year is above or below the
414 hospital's share of the state's net cost for the previous fiscal year, the underpayment or
415 overpayment of the assessment by the hospitals shall be applied to the fiscal year in which the
416 report was issued.
417 (4) A Medicaid accountable care organization shall, on or before October 15 of each
418 year, report to the department the following data from the prior state fiscal year:
419 (a) for the traditional Medicaid population, for each hospital provider:
420 (i) hospital inpatient payments;
421 (ii) hospital inpatient discharges;
422 (iii) hospital inpatient days; and
423 (iv) hospital outpatient payments; and
424 (b) for the Medicaid population newly eligible under Subsection 26-18-411, for each
425 hospital provider:
426 (i) hospital inpatient payments;
427 (ii) hospital inpatient discharges;
428 (iii) hospital inpatient days; and
429 (iv) hospital outpatient payments.
430 Section 11. Section **26-36b-205** is enacted to read:

431 **26-36b-205. Calculation of assessment.**
432 (1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a
433 quarterly basis for each hospital in an amount calculated at a uniform assessment rate for each
434 hospital discharge, in accordance with this section.
435 (b) A private teaching hospital with more than 425 beds and 60 residents shall pay an
436 assessment rate 2.75 times the uniform rate established under Subsection (1)(c).
437 (c) The uniform assessment rate shall be determined using the total number of hospital
438 discharges for assessed hospitals, the percentages in Subsection 26-36b-204(2), and rule
439 adopted by the department. The assessment may not exceed:
440 (i) the hospital share as determined in Section 26-36b-204 and the non-federal share to
441 seed amounts needed to support fee-for-service private hospital upper payment limit payments
442 divided into the total non-federal portion; and
443 (ii) consistent with the reports under Section 26-36b-204, the amount that is needed to
444 support capitated rates for Medicaid accountable care organization hospital services provided
445 to the Medicaid enrollees under the programs described in Subsection 26-36b-204(1)(a).
446 (d) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
447 all assessed hospitals.
448 (2) (a) For each state fiscal year, discharges shall be determined using the data from
449 each hospital's Medicare cost report contained in the Centers for Medicare and Medicaid
450 Services' Healthcare Cost Report Information System file. The hospital's discharge data will be
451 derived as follows:
452 (i) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year
453 ending between July 1, 2013, and June 30, 2014; and
454 (ii) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
455 fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.
456 (b) If a hospital's fiscal year Medicare cost report is not contained in the Centers for
457 Medicare and Medicaid Services' Healthcare Cost Report Information System file:
458 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
459 applicable to the assessment year; and
460 (ii) the division shall determine the hospital's discharges.
461 (c) If a hospital is not certified by the Medicare program and is not required to file a

462 Medicare cost report:
463 (i) the hospital shall submit to the division the hospital's applicable fiscal year
464 discharges with supporting documentation;
465 (ii) the division shall determine the hospital's discharges from the information
466 submitted under Subsection (2)(c)(i); and
467 (iii) the failure to submit discharge information shall result in an audit of the hospital's
468 records and a penalty equal to 5% of the calculated assessment.
469 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
470 owns more than one hospital in the state:
471 (a) the assessment for each hospital shall be separately calculated by the department;
472 and
473 (b) each separate hospital shall pay the assessment imposed by this chapter.
474 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the
475 same Medicaid provider number:
476 (a) the department shall calculate the assessment in the aggregate for the hospitals
477 using the same Medicaid provider number; and
478 (b) the hospitals may pay the assessment in the aggregate.
479 Section 12. Section **26-36b-206** is enacted to read:
480 **26-36b-206. Penalties and interest.**
481 (1) A hospital that fails to pay any assessment or file a return as required under this
482 chapter, within the time required by this chapter, shall pay penalties, in addition to the
483 assessment, and interest established by the department.
484 (2) (a) Consistent with Subsection (2)(b), the department shall adopt rules in
485 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish
486 reasonable penalties and interest for the violations described in Subsection (1).
487 (b) If a hospital fails to timely pay the full amount of a quarterly assessment, the
488 department shall add to the assessment:
489 (i) a penalty equal to 5% of the quarterly amount not paid on or before the due date;
490 and
491 (ii) on the last day of each quarter after the due date until the assessed amount and the
492 penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:

493 (A) any unpaid quarterly assessment; and
494 (B) any unpaid penalty assessment.
495 (c) Upon making a record of the division's actions, and upon reasonable cause shown,
496 the division may waive, reduce, or compromise any of the penalties imposed under this
497 chapter.
498 Section 13. Section **26-36b-207** is enacted to read:
499 **26-36b-207. Medicaid Expansion Fund.**
500 (1) There is created an expendable special revenue fund known as the Medicaid
501 Expansion Fund.
502 (2) The fund consists of:
503 (a) assessments collected under this chapter;
504 (b) savings attributable to the health coverage improvement program under Section
505 26-18-411;
506 (c) gifts, grants, donations, or any other conveyance of money that may be made to the
507 fund from private sources; and
508 (d) additional amounts as appropriated by the Legislature.
509 (3) (a) The fund shall earn interest.
510 (b) All interest earned on fund money shall be deposited into the fund.
511 (4) (a) A state agency administering the provisions of this chapter may use money from
512 the fund to pay the costs of the health coverage improvement Medicaid waiver under Section
513 26-18-411, and the outpatient UPL under Section 26-36b-204, not otherwise paid for with
514 federal funds or other revenue sources.
515 (b) Money in the fund may not be used for any other purpose.
516 Section 14. Section **26-36b-208** is enacted to read:
517 **26-36b-208. Hospital reimbursement.**
518 The department shall, to the extent allowed by law, include in the contracts with the
519 Medicaid accountable care organizations a requirement that the accountable care organization
520 reimburse hospitals in the accountable care organization's provider network, no less than the
521 Medicaid fee for service rate. Nothing in this section prohibits a Medicaid accountable care
522 organization from paying a rate that exceeds Medicaid fee-for-service rates.
523 Section 15. Section **26-36b-209** is enacted to read:

524 **26-36b-209. Outpatient upper payment limit supplemental payments.**
525 (1) For purposes of this section, "UPL gap" means the difference between the hospital
526 outpatient upper payment limit and the Medicaid outpatient payments, as determined in
527 accordance with 42 C.F.R. 447.321.
528 (2) Beginning on the effective date of the assessment imposed under this chapter, and
529 for each fiscal year thereafter, the department shall implement an outpatient upper payment
530 limit program that shall supplement the reimbursement to hospitals in accordance with
531 Subsection (3).
532 (3) The supplemental payment to hospitals under Subsection (2) shall:
533 (a) equal the positive UPL gap; and
534 (b) be allocated based on each hospital's proportional share of Medicaid fee-for-service
535 outpatient reimbursement for eligible hospitals.
536 (4) The outpatient data used to calculate the UPL gap under Subsection (1) shall be the
537 same outpatient data used to allocate the payments under Subsection (3).
538 Section 16. Section **26-36b-210** is enacted to read:
539 **26-36b-210. Repeal of assessment.**
540 (1) The repeal of the assessment imposed by this chapter shall occur upon the
541 certification by the executive director of the department that the sooner of the following has
542 occurred:
543 (a) the effective date of any action by Congress that would disqualify the assessment
544 imposed by this chapter from counting toward state Medicaid funds available to be used to
545 determine the federal financial participation;
546 (b) the effective date of any decision, enactment, or other determination by the
547 Legislature or by any court, officer, department, or agency of the state, or of the federal
548 government, that has the effect of:
549 (i) disqualifying the assessment from counting toward state Medicaid funds available
550 to be used to determine federal financial participation for Medicaid matching funds; or
551 (ii) creating for any reason a failure of the state to use the assessments for the Medicaid
552 program as described in this chapter;
553 (c) the effective date of a change that reduces the aggregate hospital inpatient and
554 outpatient payment rate below the aggregate hospital inpatient and outpatient rate for July 1,

555 2015; and
556 (d) the sunset of this chapter in accordance with Section 63I-1-226.
557 (2) If the assessment is repealed under Subsection (1), money in the fund that was
558 derived from assessments imposed by this chapter, before the determination made under
559 Subsection (1), shall be disbursed under Section 26-36b-204 to the extent federal matching is
560 not reduced due to the impermissibility of the assessments. Any funds remaining in the special
561 revenue fund shall be refunded to the hospitals in proportion to the amount paid by each
562 hospital.
563 Section 17. Section **49-20-401** is amended to read:
564 **49-20-401. Program -- Powers and duties.**
565 (1) The program shall:
566 (a) act as a self-insurer of employee benefit plans and administer those plans;
567 (b) enter into contracts with private insurers or carriers to underwrite employee benefit
568 plans as considered appropriate by the program;
569 (c) indemnify employee benefit plans or purchase commercial reinsurance as
570 considered appropriate by the program;
571 (d) provide descriptions of all employee benefit plans under this chapter in cooperation
572 with covered employers;
573 (e) process claims for all employee benefit plans under this chapter or enter into
574 contracts, after competitive bids are taken, with other benefit administrators to provide for the
575 administration of the claims process;
576 (f) obtain an annual actuarial review of all health and dental benefit plans and a
577 periodic review of all other employee benefit plans;
578 (g) consult with the covered employers to evaluate employee benefit plans and develop
579 recommendations for benefit changes;
580 (h) annually submit a budget and audited financial statements to the governor and
581 Legislature which includes total projected benefit costs and administrative costs;
582 (i) maintain reserves sufficient to liquidate the unrevealed claims liability and other
583 liabilities of the employee benefit plans as certified by the program's consulting actuary;
584 (j) submit, in advance, its recommended benefit adjustments for state employees to:
585 (i) the Legislature; and

586 (ii) the executive director of the state Department of Human Resource Management;
587 (k) determine benefits and rates, upon approval of the board, for multiemployer risk
588 pools, retiree coverage, and conversion coverage;
589 (l) determine benefits and rates based on the total estimated costs and the employee
590 premium share established by the Legislature, upon approval of the board, for state employees;
591 (m) administer benefits and rates, upon ratification of the board, for single employer
592 risk pools;
593 (n) request proposals for provider networks or health and dental benefit plans
594 administered by third party carriers at least once every three years for the purposes of:
595 (i) stimulating competition for the benefit of covered individuals;
596 (ii) establishing better geographical distribution of medical care services; and
597 (iii) providing coverage for both active and retired covered individuals;
598 (o) offer proposals which meet the criteria specified in a request for proposals and
599 accepted by the program to active and retired state covered individuals and which may be
600 offered to active and retired covered individuals of other covered employers at the option of the
601 covered employer;
602 (p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for
603 the Department of Health if the program provides program benefits to children enrolled in the
604 Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's
605 Health Insurance Act;
606 (q) establish rules and procedures governing the admission of political subdivisions or
607 educational institutions and their employees to the program;
608 (r) contract directly with medical providers to provide services for covered individuals;
609 (s) take additional actions necessary or appropriate to carry out the purposes of this
610 chapter; [~~and~~]
611 (t) (i) require state employees and their dependents to participate in the electronic
612 exchange of clinical health records in accordance with Section 26-1-37 unless the enrollee opts
613 out of participation; and
614 (ii) prior to enrolling the state employee, each time the state employee logs onto the
615 program's website, and each time the enrollee receives written enrollment information from the
616 program, provide notice to the enrollee of the enrollee's participation in the electronic exchange

617 of clinical health records and the option to opt out of participation at any time[.]; and

618 (u) provide services for drugs or medical devices at the request of a procurement unit,

619 as that term is defined in Section 63G-6a-104, that administers benefits to program recipients

620 who are not covered by Title 26, Utah Health Code.

621 (2) (a) Funds budgeted and expended shall accrue from rates paid by the covered

622 employers and covered individuals.

623 (b) Administrative costs shall be approved by the board and reported to the governor

624 and the Legislature.

625 (3) The Department of Human Resource Management shall include the benefit

626 adjustments described in Subsection (1)(j) in the total compensation plan recommended to the

627 governor required under Subsection 67-19-12(5)(a).

628 Section 18. Section **63I-1-226** is amended to read:

629 **63I-1-226. Repeal dates, Title 26.**

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

631 1, 2025.

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

633 (3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed

634 July 1, 2018.

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

636 (5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2016.

637 (6) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, 2021.

638 [(6)] (7) Section 26-38-2.5 is repealed July 1, 2017.

639 [(7)] (8) Section 26-38-2.6 is repealed July 1, 2017.

640 [(8)] (9) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.

Legislative Review Note
Office of Legislative Research and General Counsel