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Representative James A. Dunnigan proposes the following substitute bill:

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 savings from 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
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 This bill appropriates $2,508,500 ongoing General Fund from other programs to the
40 Medicaid Expansion Fund and makes changes to other funds.
41 **Other Special Clauses:**
42 This bill provides a coordination clause.
43 **Utah Code Sections Affected:**
44 AMENDS:
45 **26-18-2.4**, as last amended by Laws of Utah 2012, Chapters 242 and 343
46 **26-18-18**, as last amended by Laws of Utah 2015, Chapter 283
47 **49-20-401**, as last amended by Laws of Utah 2015, Chapter 155
48 **63I-1-226**, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258
49 ENACTS:
50 **26-18-411**, Utah Code Annotated 1953
51 **26-36b-101**, Utah Code Annotated 1953
52 **26-36b-102**, Utah Code Annotated 1953
53 **26-36b-103**, Utah Code Annotated 1953
54 **26-36b-201**, Utah Code Annotated 1953
55 **26-36b-202**, Utah Code Annotated 1953
56 **26-36b-203**, Utah Code Annotated 1953

57 **26-36b-204**, Utah Code Annotated 1953
58 **26-36b-205**, Utah Code Annotated 1953
59 **26-36b-206**, Utah Code Annotated 1953
60 **26-36b-207**, Utah Code Annotated 1953
61 **26-36b-208**, Utah Code Annotated 1953
62 **26-36b-209**, Utah Code Annotated 1953
63 **26-36b-210**, Utah Code Annotated 1953
64 **Utah Code Sections Affected by Coordination Clause:**
65 **26-18-2.4**, as last amended by Laws of Utah 2012, Chapters 242 and 343
66

67 *Be it enacted by the Legislature of the state of Utah:*
68 Section 1. Section **26-18-2.4** is amended to read:
69 **26-18-2.4. Medicaid drug program -- Preferred drug list.**
70 (1) A Medicaid drug program developed by the department under Subsection
71 26-18-2.3(2)(f):
72 (a) shall, notwithstanding Subsection 26-18-2.3(1)(b), be based on clinical and
73 cost-related factors which include medical necessity as determined by a provider in accordance
74 with administrative rules established by the Drug Utilization Review Board;
75 (b) may include therapeutic categories of drugs that may be exempted from the drug
76 program;
77 (c) may include placing some drugs, except the drugs described in Subsection (2), on a
78 preferred drug list:
79 (i) to the extent determined appropriate by the department; and
80 (ii) in the manner described in Subsection (3) for psychotropic drugs;
81 (d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and
82 except as provided in Subsection (3), shall immediately implement the prior authorization
83 requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:
84 (i) on the preferred drug list on the date that this act takes effect; or
85 (ii) added to the preferred drug list after this act takes effect; and
86 (e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior
87 authorization requirements established under Subsections (1)(c) and (d) which shall permit a

health care provider or the health care provider's agent to obtain a prior authorization override of the preferred drug list through the department's pharmacy prior authorization review process, and which shall:

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

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

(iii) require the health care provider to provide the department with documentation of the medical need for the preferred drug list override in accordance with criteria established by the department in consultation with the Pharmacy and Therapeutics Committee.

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

(i) "Immunosuppressive drug":

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

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

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

[(iii)] (ii) "Stabilized" means a health care provider has documented in the patient's medical chart that a patient has achieved a stable or steadfast medical state within the past 90 days using a particular psychotropic drug.

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

(c) The state Medicaid program shall reimburse for a prescription for an immunosuppressive drug as written by the health care provider for a patient who has undergone an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to patients

119 who have undergone an organ transplant, the prescription for a particular immunosuppressive
120 drug as written by a health care provider meets the criteria of demonstrating to the Department
121 of Health a medical necessity for dispensing the prescribed immunosuppressive drug.
122 (d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the
123 state Medicaid drug program may not require the use of step therapy for immunosuppressive
124 drugs without the written or oral consent of the health care provider and the patient.
125 (e) The department may include a sedative hypnotic on a preferred drug list in
126 accordance with Subsection (2)(f).
127 (f) The department shall grant a prior authorization for a sedative hypnotic that is not
128 on the preferred drug list under Subsection (2)(e), if the health care provider has documentation
129 related to one of the following conditions for the Medicaid client:
130 (i) a trial and failure of at least one preferred agent in the drug class, including the
131 name of the preferred drug that was tried, the length of therapy, and the reason for the
132 discontinuation;
133 (ii) detailed evidence of a potential drug interaction between current medication and
134 the preferred drug;
135 (iii) detailed evidence of a condition or contraindication that prevents the use of the
136 preferred drug;
137 (iv) objective clinical evidence that a patient is at high risk of adverse events due to a
138 therapeutic interchange with a preferred drug;
139 (v) the patient is a new or previous Medicaid client with an existing diagnosis
140 previously stabilized with a nonpreferred drug; or
141 (vi) other valid reasons as determined by the department.
142 (g) A prior authorization granted under Subsection (2)(f) is valid for one year from the
143 date the department grants the prior authorization and shall be renewed in accordance with
144 Subsection (2)(f).
145 (3) (a) For purposes of this Subsection (3), "psychotropic drug" means the following
146 classes of drugs:
147 (i) atypical anti-psychotic;
148 (ii) anti-depressant;
149 (iii) anti-convulsant/mood stabilizer;

150 (iv) anti-anxiety; and
151 (v) attention deficit hyperactivity disorder stimulant.
152 (b) The department shall, by July 1, 2016, develop a preferred drug list for
153 psychotropic drugs. Except as provided in Subsection (3)(d), a preferred drug list for
154 psychotropic drugs developed under this section shall allow a health care provider to override
155 the preferred drug list by writing "dispense as written" on the prescription for the psychotropic
156 drug. A health care provider may not override Section 58-17b-606 by writing "dispense as
157 written" on a prescription.
158 (c) The department, and a Medicaid accountable care organization that is responsible
159 for providing behavioral health, shall:
160 (i) establish a system to:
161 (A) track health care provider prescribing patterns for psychotropic drugs;
162 (B) educate health care providers who are not complying with the preferred drug list;
163 and
164 (C) implement peer to peer education for health care providers whose prescribing
165 practices continue to not comply with the preferred drug list; and
166 (ii) determine whether health care provider compliance with the preferred drug list is at
167 least:
168 (A) 55% of prescriptions by July 1, 2017;
169 (B) 65% of prescriptions by July 1, 2018; and
170 (C) 75% of prescriptions by July 1, 2019.
171 (d) Beginning October 1, 2019, the department shall eliminate the dispense as written
172 override for the preferred drug list, and shall implement a prior authorization system for
173 psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has
174 not realized annual savings from implementing the preferred drug list for psychotropic drugs of
175 at least $1,500,000.
176 (e) The department shall report to the Health and Human Services Interim Committee
177 and the Social Services Appropriations Subcommittee before November 30, 2016, and before
178 each November 30 thereafter regarding compliance with and savings from implementation of
179 Subsection (3).
180 [~~(3)~~] (4) The department shall report to the Health and Human Services Interim

181 Committee and to the Social Services Appropriations Subcommittee prior to November 1,
182 2013, regarding the savings to the Medicaid program resulting from the use of the preferred
183 drug list permitted by Subsection (1).
184 Section 2. Section **26-18-18** is amended to read:
185 **26-18-18. Optional Medicaid expansion.**
186 (1) For purposes of this section [~~PPACA is as~~], "PPACA" means the same as that term
187 is defined in Section 31A-1-301.
188 (2) The department and the governor shall not expand the state's Medicaid program to
189 the optional population under PPACA unless:
190 [~~(a) the Health Reform Task Force has completed a thorough analysis of a statewide~~
191 ~~charity care system;~~]
192 [~~(b) the department and its contractors have:~~]
193 [~~(i) completed a thorough analysis of the impact to the state of expanding the state's~~
194 ~~Medicaid program to optional populations under PPACA; and~~]
195 [~~(ii) made the analysis conducted under Subsection (2)(b)(i) available to the public;~~]
196 [~~(c)~~] (a) the governor or the governor's designee has reported the intention to expand
197 the state Medicaid program under PPACA to the Legislature in compliance with the legislative
198 review process in Sections 63N-11-106 and 26-18-3; and
199 [~~(d)~~] (b) (i) notwithstanding Subsection 63J-5-103(2), the governor submits the request
200 for expansion of the Medicaid program for optional populations to the Legislature under the
201 high impact federal funds request process required by Section 63J-5-204, Legislative review
202 and approval of certain federal funds request[~~.~~]; or
203 (ii) the department obtains approval from the Centers for Medicare and Medicaid
204 Services within the United States Department of Health and Human Services for waivers from
205 federal statutory and regulatory law necessary to implement the health coverage improvement
206 program under Section 26-18-411.
207 Section 3. Section **26-18-411** is enacted to read:
208 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
209 **-- Expansion of eligibility for adults with dependent children.**
210 (1) For purposes of this section:
211 (a) "Adult in the expansion population" means an individual who:

212 (i) is described in 42 U.S.C. Sec. 1396a(10)(A)(i)(VIII); and
213 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
214 individual.
215 (b) "CMS" means the Centers for Medicare and Medicaid Services within the United
216 States Department of Health and Human Services.
217 (c) "Federal poverty level" means the poverty guidelines established by the secretary of
218 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).
219 (d) "Homeless":
220 (i) means an individual who is chronically homeless, as determined by the department;
221 and
222 (ii) includes someone who was chronically homeless and is currently living in
223 supported housing for the chronically homeless.
224 (e) "Income eligibility ceiling" means the percent of federal poverty level:
225 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
226 Chapter 1, Budgetary Procedures Act; and
227 (ii) under which an individual may qualify for Medicaid coverage in accordance with
228 this section.
229 (2) (a) No later than July 1, 2016, the division shall submit to CMS a request for
230 waivers, or an amendment of existing waivers, from federal statutory and regulatory law
231 necessary for the state to implement the health coverage improvement program in the Medicaid
232 program in accordance with this section.
233 (b) An adult in the expansion population is eligible for Medicaid if the adult meets the
234 income eligibility and other criteria established under Subsection (3).
235 (c) An adult who qualifies under Subsection (3) shall receive Medicaid coverage:
236 (i) through:
237 (A) the traditional fee for service Medicaid model in counties without Medicaid
238 accountable care organizations or the state's Medicaid accountable care organization delivery
239 system, where implemented; and
240 (B) except as provided in Subsection (2)(c)(ii), for behavioral health, through the
241 counties in accordance with Sections 17-43-201 and 17-43-301;
242 (ii) that integrates behavioral health services and physical health services in selected

243 geographic areas of the state with Medicaid accountable care organizations; and
244 (iii) that permits residential treatment in a facility without a bed capacity limit, as
245 approved by CMS.
246 (d) Medicaid accountable care organizations and counties that integrate care under
247 Subsection (2)(c)(ii) shall collaborate on enrollment, engagement of patients, and coordination
248 of services.
249 (3) (a) An individual is eligible for the health coverage improvement program under
250 Subsection (2)(b) if:
251 (i) at the time of enrollment, the individual's annual income is below the income
252 eligibility ceiling established by the state under Subsection (1)(e); and
253 (ii) the individual meets the eligibility criteria established by the department under
254 Subsection (3)(b).
255 (b) Based on available funding and approval from CMS, the department shall select the
256 criteria for an individual to qualify for the Medicaid program under Subsection (3)(a)(ii), based
257 on the following priority:
258 (i) a chronically homeless individual;
259 (ii) if funding is available, an individual:
260 (A) involved in the justice system through probation, parole, or court ordered
261 treatment; and
262 (B) in need of substance abuse treatment or mental health treatment, as determined by
263 the department; or
264 (iii) if funding is available, an individual in need of substance abuse treatment or
265 mental health treatment, as determined by the department.
266 (c) An individual who qualifies for Medicaid coverage under Subsection (3)(a) and (b)
267 may remain on the Medicaid program for 12 months, and changes to eligibility criteria during
268 that 12-month period do not apply to that individual until the individual re-applies for the
269 Medicaid program at the end of the 12-month enrollment.
270 (4) The state may request a modification of the income eligibility ceiling and other
271 eligibility criteria under Subsection (3) each fiscal year based on enrollment in the health
272 coverage improvement program, projected enrollment, costs to the state, and the state budget.
273 (5) On or before September 30, 2017, and on or before September 30 each year

274 thereafter, the department shall report to the Legislature's Health and Human Services Interim
275 Committee and to the Legislature's Executive Appropriations Committee:
276 (a) the number of individuals who enrolled in Medicaid under Subsection (2);
277 (b) the state cost of providing Medicaid to individuals enrolled under Subsection (2);
278 and
279 (c) recommendations for adjusting the income eligibility ceiling under Subsection (4),
280 and other eligibility criteria under Subsection (3), for the upcoming fiscal year.
281 (6) In addition to the waiver under Subsection (2), beginning July 1, 2016, the
282 department shall amend the state Medicaid plan:
283 (a) for an individual with a dependent child, to increase the income eligibility ceiling to
284 a percent of the federal poverty level designated by the department, based on appropriations for
285 the program; and
286 (b) to allow residential treatment for the traditional current Medicaid population at
287 facilities with no bed capacity limits, as long as the county makes the match required under
288 Sections 17-43-201 and 17-43-301.
289 (7) The current Medicaid program and the health coverage improvement program,
290 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
291 enrollment for an individual who is released from custody and was eligible for or enrolled in
292 Medicaid before incarceration.
293 (8) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
294 provide matching funds to the state for the cost of providing Medicaid services to newly
295 enrolled individuals who qualify for Medicaid coverage under the health coverage
296 improvement program under Subsection (3).
297 (9) The department shall:
298 (a) study, in consultation with health care providers, employers, uninsured families,
299 and community stakeholders:
300 (i) options to maximize use of employer sponsored coverage for current Medicaid
301 enrollees; and
302 (ii) strategies to increase participation of currently Medicaid eligible, and uninsured,
303 children; and
304 (b) report the findings of the study to the Legislature's Health Reform Task Force

305 before November 30, 2016.
306 Section 4. Section **26-36b-101** is enacted to read:
307 **CHAPTER 36b. INPATIENT HOSPITAL ASSESSMENT ACT**
308 **Part 1. General Provisions**
309 **26-36b-101. Title.**
310 This chapter is known as "Inpatient Hospital Assessment Act."
311 Section 5. Section **26-36b-102** is enacted to read:
312 **26-36b-102. Application.**
313 (1) Other than for the imposition of the assessment described in this chapter, nothing in
314 this chapter shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious,
315 or educational health care provider under:
316 (a) Section 501(c), as amended, of the Internal Revenue Code;
317 (b) other applicable federal law;
318 (c) any state law;
319 (d) any ad valorem property taxes;
320 (e) any sales or use taxes; or
321 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed, by
322 the state or any political subdivision, county, municipality, district, authority, or any agency or
323 department thereof.
324 (2) All assessments paid under this chapter may be included as an allowable cost of a
325 hospital for purposes of any applicable Medicaid reimbursement formula.
326 (3) This chapter does not authorize a political subdivision of the state to:
327 (a) license a hospital for revenue;
328 (b) impose a tax or assessment upon a hospital; or
329 (c) impose a tax or assessment measured by the income or earnings of a hospital.
330 Section 6. Section **26-36b-103** is enacted to read:
331 **26-36b-103. Definitions.**
332 As used in this chapter:
333 (1) "Assessment" means the inpatient hospital assessment established by this chapter.
334 (2) "Discharges" means the number of total hospital discharges reported on:
335 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost

336 report for the applicable assessment year; or
337 (b) a similar report adopted by the department by administrative rule, if the report
338 under Subsection (2)(a) is no longer available.
339 (3) "Division" means the Division of Health Care Financing within the department.
340 (4) "Hospital":
341 (a) means:
342 (i) a privately owned general acute hospital operating in the state as defined in Section
343 26-21-2;
344 (ii) a privately owned specialty hospital operating in the state, which shall include a
345 privately owned hospital whose inpatient admissions are predominantly:
346 (A) rehabilitation;
347 (B) psychiatric;
348 (C) chemical dependency; or
349 (D) long-term acute care services;
350 (iii) a state owned teaching hospital that is part of an institution of higher education;
351 and
352 (iv) a hospital owned by a non-state government entity; and
353 (b) does not include:
354 (i) a residential care or treatment facility as defined in Section 62A-2-101;
355 (ii) a hospital owned by the federal government, including the Veterans Administration
356 Hospital; or
357 (iii) the Utah State Hospital.
358 (5) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of
359 hospitals.
360 Section 7. Section **26-36b-201** is enacted to read:
361 **Part 2. Assessment and Collection**
362 **26-36b-201. Assessment.**
363 (1) A uniform, broad based assessment is imposed on each hospital:
364 (a) beginning when the Centers for Medicare and Medicaid Services within the United
365 States Department of Health and Human Services approves:
366 (i) the health coverage improvement program waiver under Section 26-18-411; and

367 (ii) the assessment under this chapter;
368 (b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and
369 (c) in accordance with Section 26-36b-202.
370 (2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and
371 payable on a quarterly basis.
372 Section 8. Section **26-36b-202** is enacted to read:
373 **26-36b-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**
374 (1) The collecting agent for assessment imposed under Section 26-36b-201 is the
375 department. The department is vested with the administration and enforcement of this chapter,
376 including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah
377 Administrative Rulemaking Act, necessary to:
378 (a) implement and enforce the provisions of this chapter;
379 (b) audit records of a facility that:
380 (i) is subject to the assessment imposed by this chapter; and
381 (ii) does not file a Medicare cost report; and
382 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
383 Medicare cost report.
384 (2) The department shall:
385 (a) administer the assessment in this part separate from the assessment in Chapter 36a,
386 Hospital Provider Assessment Act; and
387 (b) deposit assessments collected under this chapter in the Medicaid Expansion Fund
388 created by Section 26-36b-207.
389 Section 9. Section **26-36b-203** is enacted to read:
390 **26-36b-203. Quarterly notice.**
391 Quarterly assessments imposed by this chapter shall be paid to the division within 15
392 business days after the original invoice date that appears on the invoice issued by the division.
393 The department may, by rule, extend the time for paying the assessment.
394 Section 10. Section **26-36b-204** is enacted to read:
395 **26-36b-204. Hospital financing of health coverage improvement program**
396 **Medicaid waiver -- Hospital share.**
397 (1) For purposes of this section, "hospital share":

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

429 (i) hospital inpatient payments;
430 (ii) hospital inpatient discharges;
431 (iii) hospital inpatient days; and
432 (iv) hospital outpatient payments.
433 Section 11. Section **26-36b-205** is enacted to read:
434 **26-36b-205. Calculation of assessment.**
435 (1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a
436 quarterly basis for each hospital in an amount calculated at a uniform assessment rate for each
437 hospital discharge, in accordance with this section.
438 (b) A private teaching hospital with more than 425 beds and 60 residents shall pay an
439 assessment rate 2.75 times the uniform rate established under Subsection (1)(c).
440 (c) The uniform assessment rate shall be determined using the total number of hospital
441 discharges for assessed hospitals, the percentages in Subsection 26-36b-204(2), and rule
442 adopted by the department. The assessment may not exceed:
443 (i) the hospital share as determined in Section 26-36b-204 and the non-federal share to
444 seed amounts needed to support fee-for-service private hospital upper payment limit payments
445 divided into the total non-federal portion; and
446 (ii) consistent with the reports under Section 26-36b-204, the amount that is needed to
447 support capitated rates for Medicaid accountable care organization hospital services provided
448 to the Medicaid enrollees under the programs described in Subsection 26-36b-204(1)(a).
449 (d) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
450 all assessed hospitals.
451 (2) (a) For each state fiscal year, discharges shall be determined using the data from
452 each hospital's Medicare cost report contained in the Centers for Medicare and Medicaid
453 Services' Healthcare Cost Report Information System file. The hospital's discharge data will be
454 derived as follows:
455 (i) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year
456 ending between July 1, 2013, and June 30, 2014; and
457 (ii) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
458 fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.
459 (b) If a hospital's fiscal year Medicare cost report is not contained in the Centers for

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

491 department shall add to the assessment:
492 (i) a penalty equal to 5% of the quarterly amount not paid on or before the due date;
493 and
494 (ii) on the last day of each quarter after the due date until the assessed amount and the
495 penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:
496 (A) any unpaid quarterly assessment; and
497 (B) any unpaid penalty assessment.
498 (c) Upon making a record of the division's actions, and upon reasonable cause shown,
499 the division may waive, reduce, or compromise any of the penalties imposed under this
500 chapter.
501 Section 13. Section **26-36b-207** is enacted to read:
502 **26-36b-207. Medicaid Expansion Fund.**
503 (1) There is created an expendable special revenue fund known as the Medicaid
504 Expansion Fund.
505 (2) The fund consists of:
506 (a) assessments collected under this chapter;
507 (b) savings attributable to the health coverage improvement program under Section
508 26-18-411;
509 (c) savings attributable to the inclusion of psychotropic drugs on the preferred drug list
510 under Subsection 26-18-2.4(3);
511 (d) savings attributable to the services provided by the Public Employees' Health Plan
512 under Subsection 49-20-401(1)(u);
513 (e) gifts, grants, donations, or any other conveyance of money that may be made to the
514 fund from private sources; and
515 (f) additional amounts as appropriated by the Legislature.
516 (3) (a) The fund shall earn interest.
517 (b) All interest earned on fund money shall be deposited into the fund.
518 (4) (a) A state agency administering the provisions of this chapter may use money from
519 the fund to pay the costs of the health coverage improvement Medicaid waiver under Section
520 26-18-411, and the outpatient UPL under Section 26-36b-204, not otherwise paid for with
521 federal funds or other revenue sources.

522 (b) Money in the fund may not be used for any other purpose.
523 Section 14. Section **26-36b-208** is enacted to read:
524 **26-36b-208. Hospital reimbursement.**
525 The department shall, to the extent allowed by law, include in the contracts with the
526 Medicaid accountable care organizations a requirement that the accountable care organization
527 reimburse hospitals in the accountable care organization's provider network, no less than the
528 Medicaid fee for service rate. Nothing in this section prohibits a Medicaid accountable care
529 organization from paying a rate that exceeds Medicaid fee-for-service rates.
530 Section 15. Section **26-36b-209** is enacted to read:
531 **26-36b-209. Outpatient upper payment limit supplemental payments.**
532 (1) For purposes of this section, "UPL gap" means the difference between the hospital
533 outpatient upper payment limit and the Medicaid outpatient payments, as determined in
534 accordance with 42 C.F.R. 447.321.
535 (2) Beginning on the effective date of the assessment imposed under this chapter, and
536 for each fiscal year thereafter, the department shall implement an outpatient upper payment
537 limit program that shall supplement the reimbursement to hospitals in accordance with
538 Subsection (3).
539 (3) The supplemental payment to hospitals under Subsection (2) shall:
540 (a) equal the positive UPL gap; and
541 (b) be allocated based on each hospital's proportional share of Medicaid fee-for-service
542 outpatient reimbursement for eligible hospitals.
543 (4) The outpatient data used to calculate the UPL gap under Subsection (1) shall be the
544 same outpatient data used to allocate the payments under Subsection (3).
545 Section 16. Section **26-36b-210** is enacted to read:
546 **26-36b-210. Repeal of assessment.**
547 (1) The repeal of the assessment imposed by this chapter shall occur upon the
548 certification by the executive director of the department that the sooner of the following has
549 occurred:
550 (a) the effective date of any action by Congress that would disqualify the assessment
551 imposed by this chapter from counting toward state Medicaid funds available to be used to
552 determine the federal financial participation;

553 (b) the effective date of any decision, enactment, or other determination by the
554 Legislature or by any court, officer, department, or agency of the state, or of the federal
555 government, that has the effect of:
556 (i) disqualifying the assessment from counting toward state Medicaid funds available
557 to be used to determine federal financial participation for Medicaid matching funds; or
558 (ii) creating for any reason a failure of the state to use the assessments for the Medicaid
559 program as described in this chapter;
560 (c) the effective date of a change that reduces the aggregate hospital inpatient and
561 outpatient payment rate below the aggregate hospital inpatient and outpatient rate for July 1,
562 2015; and
563 (d) the sunset of this chapter in accordance with Section 63I-1-226.
564 (2) If the assessment is repealed under Subsection (1), money in the fund that was
565 derived from assessments imposed by this chapter, before the determination made under
566 Subsection (1), shall be disbursed under Section 26-36b-204 to the extent federal matching is
567 not reduced due to the impermissibility of the assessments. Any funds remaining in the special
568 revenue fund shall be refunded to the hospitals in proportion to the amount paid by each
569 hospital.
570 Section 17. Section **49-20-401** is amended to read:
571 **49-20-401. Program -- Powers and duties.**
572 (1) The program shall:
573 (a) act as a self-insurer of employee benefit plans and administer those plans;
574 (b) enter into contracts with private insurers or carriers to underwrite employee benefit
575 plans as considered appropriate by the program;
576 (c) indemnify employee benefit plans or purchase commercial reinsurance as
577 considered appropriate by the program;
578 (d) provide descriptions of all employee benefit plans under this chapter in cooperation
579 with covered employers;
580 (e) process claims for all employee benefit plans under this chapter or enter into
581 contracts, after competitive bids are taken, with other benefit administrators to provide for the
582 administration of the claims process;
583 (f) obtain an annual actuarial review of all health and dental benefit plans and a

584 periodic review of all other employee benefit plans;
585 (g) consult with the covered employers to evaluate employee benefit plans and develop
586 recommendations for benefit changes;
587 (h) annually submit a budget and audited financial statements to the governor and
588 Legislature which includes total projected benefit costs and administrative costs;
589 (i) maintain reserves sufficient to liquidate the unrevealed claims liability and other
590 liabilities of the employee benefit plans as certified by the program's consulting actuary;
591 (j) submit, in advance, its recommended benefit adjustments for state employees to:
592 (i) the Legislature; and
593 (ii) the executive director of the state Department of Human Resource Management;
594 (k) determine benefits and rates, upon approval of the board, for multiemployer risk
595 pools, retiree coverage, and conversion coverage;
596 (l) determine benefits and rates based on the total estimated costs and the employee
597 premium share established by the Legislature, upon approval of the board, for state employees;
598 (m) administer benefits and rates, upon ratification of the board, for single employer
599 risk pools;
600 (n) request proposals for provider networks or health and dental benefit plans
601 administered by third party carriers at least once every three years for the purposes of:
602 (i) stimulating competition for the benefit of covered individuals;
603 (ii) establishing better geographical distribution of medical care services; and
604 (iii) providing coverage for both active and retired covered individuals;
605 (o) offer proposals which meet the criteria specified in a request for proposals and
606 accepted by the program to active and retired state covered individuals and which may be
607 offered to active and retired covered individuals of other covered employers at the option of the
608 covered employer;
609 (p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for
610 the Department of Health if the program provides program benefits to children enrolled in the
611 Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's
612 Health Insurance Act;
613 (q) establish rules and procedures governing the admission of political subdivisions or
614 educational institutions and their employees to the program;

615 (r) contract directly with medical providers to provide services for covered individuals;
616 (s) take additional actions necessary or appropriate to carry out the purposes of this
617 chapter; [~~and~~]
618 (t) (i) require state employees and their dependents to participate in the electronic
619 exchange of clinical health records in accordance with Section 26-1-37 unless the enrollee opts
620 out of participation; and
621 (ii) prior to enrolling the state employee, each time the state employee logs onto the
622 program's website, and each time the enrollee receives written enrollment information from the
623 program, provide notice to the enrollee of the enrollee's participation in the electronic exchange
624 of clinical health records and the option to opt out of participation at any time[~~.~~]; and
625 (u) provide services for drugs or medical devices at the request of a procurement unit,
626 as that term is defined in Section 63G-6a-104, that administers benefits to program recipients
627 who are not covered by Title 26, Utah Health Code.
628 (2) (a) Funds budgeted and expended shall accrue from rates paid by the covered
629 employers and covered individuals.
630 (b) Administrative costs shall be approved by the board and reported to the governor
631 and the Legislature.
632 (3) The Department of Human Resource Management shall include the benefit
633 adjustments described in Subsection (1)(j) in the total compensation plan recommended to the
634 governor required under Subsection 67-19-12(5)(a).
635 Section 18. Section **63I-1-226** is amended to read:
636 **63I-1-226. Repeal dates, Title 26.**
637 (1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July
638 1, 2025.
639 (2) Section 26-10-11 is repealed July 1, 2020.
640 (3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed
641 July 1, 2018.
642 (4) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.
643 (5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2016.
644 (6) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, 2021.
645 [~~(6)~~] (7) Section 26-38-2.5 is repealed July 1, 2017.

646 [(7)] (8) Section 26-38-2.6 is repealed July 1, 2017.
647 [(8)] (9) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.
648 Section 19. **Appropriation.**
649 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for
650 the fiscal year beginning July 1, 2016, and ending June 30, 2017, the following sums of money
651 are appropriated from resources not otherwise appropriated, or reduced from amounts
652 previously appropriated, out of the funds or amounts indicated. These sums of money are in
653 addition to amounts previously appropriated for fiscal year 2017.

654	To Fund and Account Transfers -- State Endowment Fund		
655	From General Fund Restricted -- Tobacco Settlement Account		(1,488,700)
656	Schedule of Programs:		
657	State Endowment Fund	(1,488,700)	
658	To Department of Health -- Medicaid Optional Services		
659	From General Fund		(1,488,700)
660	From General Fund Restricted -- Tobacco Settlement Account		1,488,700
661	To Department of Human Services -- Substance Abuse and Mental Health		
662	From General Fund		(819,800)
663	From Federal Funds		819,800
664	To Department of Human Services -- Child and Family Services		
665	From General Fund		(200,000)
666	Schedule of Programs:		
667	Out-of-home Care	(200,000)	
668	To Department of Health -- Medicaid Expansion Fund		
669	From General Fund		4,808,500
670	Schedule of Programs:		
671	Medicaid Expansion Fund	5,108,500	

672 Section 20. **Coordinating H.B. 437 with H.B. 18 -- Superseding amendment.**
673 If this H.B. 437 and H.B. 18, Medicaid Preferred Drug List Amendments, both pass and
674 become law, it is the intent of the Legislature that the amendments to Section 26-18-2.4 in this
675 bill supersede the amendments to Section 26-18-2.4 in H.B. 18, when the Office of Legislative
676 Research and General Counsel prepares the Utah Code database for publication.