MEDICAID EXPANSION REVISIONS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Robert M. Spendlove

Senate Sponsor: Brian Zehnder

LONG TITLE

General Description:

This bill amends the state Medicaid program to permit an expansion of Medicaid eligibility under certain conditions.

Highlighted Provisions:

This bill:

- requires the Department of Health to submit a waiver request to the federal government by January 1, 2019, to:
  - provide Medicaid benefits to eligible individuals who are below 95% of the federal poverty level;
  - offer services to Medicaid enrollees through the Medicaid managed care organizations;
  - obtain maximum federal financial participation for the new Medicaid enrollees;
  - require certain qualified adults to meet a work activity requirement; and
  - obtain options for flexibility on enrollment;
- makes changes to the inpatient hospital assessment;
- creates a new Medicaid expansion hospital assessment;
- amends the sunset date for the inpatient hospital assessment and creates a sunset date for the Medicaid expansion hospital assessment; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides coordination clauses.

Utah Code Sections Affected:

AMENDS:

26-18-18, as last amended by Laws of Utah 2017, Chapter 247

26-36b-103, as enacted by Laws of Utah 2016, Chapter 279

26-36b-201, as enacted by Laws of Utah 2016, Chapter 279

26-36b-202, as enacted by Laws of Utah 2016, Chapter 279

26-36b-203, as enacted by Laws of Utah 2016, Chapter 279

26-36b-204, as enacted by Laws of Utah 2016, Chapter 279

26-36b-205, as enacted by Laws of Utah 2016, Chapter 279

26-36b-206, as enacted by Laws of Utah 2016, Chapter 279

26-36b-207, as enacted by Laws of Utah 2016, Chapter 279

26-36b-208, as enacted by Laws of Utah 2016, Chapter 279

26-36b-209, as enacted by Laws of Utah 2016, Chapter 279

26-36b-210, as enacted by Laws of Utah 2016, Chapter 279

26-36b-211, as enacted by Laws of Utah 2016, Chapter 279

63I-1-226, as last amended by Laws of Utah 2017, Chapters 177 and 443

ENACTS:

26-18-415, Utah Code Annotated 1953

26-36c-101, Utah Code Annotated 1953

26-36c-102, Utah Code Annotated 1953

26-36c-103, Utah Code Annotated 1953

26-36c-201, Utah Code Annotated 1953

26-36c-202, Utah Code Annotated 1953

26-36c-203, Utah Code Annotated 1953

26-36c-204, Utah Code Annotated 1953

26-36c-205, Utah Code Annotated 1953

26-36c-206, Utah Code Annotated 1953

26-36c-207, Utah Code Annotated 1953

26-36c-208, Utah Code Annotated 1953

26-36c-209, Utah Code Annotated 1953

26-36c-210, Utah Code Annotated 1953

Utah Code Sections Affected by Coordination Clause:

26-36b-103, as enacted by Laws of Utah 2016, Chapter 279

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-18-18** is amended to read:

26-18-18. Optional Medicaid expansion.

(1) For purposes of this section[~~,~~]:

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

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

(2) The department and the governor [~~shall~~] may not expand the state's Medicaid program [~~to the optional population~~] under PPACA unless:

(a) the department expands Medicaid in accordance with Section 26-18-415; or

[~~(a)~~] (b) (i) the governor or the governor's designee has reported the intention to expand the state Medicaid program under PPACA to the Legislature in compliance with the legislative review process in Sections 63N-11-106 and 26-18-3; and

[~~(b)~~] (ii) the governor submits the request for expansion of the Medicaid program for optional populations to the Legislature under the high impact federal funds request process required by Section 63J-5-204[~~, Legislative review and approval of certain federal funds request~~].

(3) (a) The department shall request approval from [~~the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services~~] CMS for waivers from federal statutory and regulatory law necessary to implement the health coverage improvement program under Section 26-18-411.

(b) The health coverage improvement program under Section 26-18-411 is not [~~Medicaid expansion for purposes of this section~~] subject to the requirements in Subsection (2).

Section 2. Section **26-18-415** is enacted to read:

26-18-415. Medicaid waiver expansion.

(1) As used in this section:

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

(b) "Expansion population" means individuals:

(i) whose household income is less than 95% of the federal poverty level; and

(ii) who are not eligible for enrollment in the Medicaid program, with the exception of the Primary Care Network program, on May 8, 2018.

(c) "Federal poverty level" means the same as that term is defined in Section 26-18-411.

(d) "Medicaid waiver expansion" means a Medicaid expansion in accordance with this section.

(2) (a) Before January 1, 2019, the department shall apply to CMS for approval of a waiver or state plan amendment to implement the Medicaid waiver expansion.

(b) The Medicaid waiver expansion shall:

(i) expand Medicaid coverage to eligible individuals whose income is below 95% of the federal poverty level;

(ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for enrolling an individual in the Medicaid program;

(iii) provide Medicaid benefits through the state's Medicaid accountable care organizations in areas where a Medicaid accountable care organization is implemented;

(iv) integrate the delivery of behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model;

(v) include a path to self-sufficiency, including work activities as defined in 42 U.S.C.

Sec. 607(d), for qualified adults;

(vi) require an individual who is offered a private health benefit plan by an employer to enroll in the employer's health plan;

(vii) sunset in accordance with Subsection (5)(a); and

(viii) permit the state to close enrollment in the Medicaid waiver expansion if the department has insufficient funding to provide services to additional eligible individuals.

(3) If the Medicaid waiver described in Subsection (1) is approved, the department may only pay the state portion of costs for the Medicaid waiver expansion with appropriations from:

(a) the Medicaid Expansion Fund, created in Section 26-36b-208;

(b) county contributions to the non-federal share of Medicaid expenditures; and

(c) any other contributions, funds, or transfers from a non-state agency for Medicaid expenditures.

(4) Medicaid accountable care organizations and counties that elect to integrate care under Subsection (2)(b)(iv) shall collaborate on enrollment, engagement of patients, and coordination of services.

(5) (a) If federal financial participation for the Medicaid waiver expansion is reduced below 90%, the authority of the department to implement the Medicaid waiver expansion shall sunset no later than the next July 1 after the date on which the federal financial participation is reduced.

(b) The department shall close the program to new enrollment if the cost of the Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are authorized by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.

(6) If the Medicaid waiver expansion is approved by CMS, the department shall report to the Social Services Appropriations Subcommittee on or before November 1 of each year that the Medicaid waiver expansion is operational:

(a) the number of individuals who enrolled in the Medicaid waiver program;

(b) costs to the state for the Medicaid waiver program;

(c) estimated costs for the current and following state fiscal year; and

(d) recommendations to control costs of the Medicaid waiver expansion.

Section 3. Section **26-36b-103** is amended to read:

26-36b-103. Definitions.

As used in this chapter:

(1) "Assessment" means the inpatient hospital assessment established by this chapter.

(2) "CMS" means the [~~same as that term is defined in Section 26-18-411~~] Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

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

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.

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

(5) "Health coverage improvement program" means the health coverage improvement program described in Section 26-18-411.

(6) "Hospital share" means the hospital share described in Section 26-36b-203.

(7) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26-18-405.

(8) "Medicaid waiver expansion" means a Medicaid expansion in accordance with Section 26-18-415.

[~~(5)~~] (9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

[~~(6)~~] (10) (a) "Non-state government hospital"[~~:(a)~~] means a hospital owned by a non-state government entity[~~; and~~].

(b) "Non-state government hospital" does not include:

(i) the Utah State Hospital; or

(ii) a hospital owned by the federal government, including the Veterans Administration Hospital.

[~~(7)~~] (11) (a) "Private hospital"[~~:(a)~~] means:

(i) a [~~privately owned~~] general acute hospital [~~operating in the state~~], as defined in Section 26-21-2, that is privately owned and operating in the state; and

(ii) a privately owned specialty hospital operating in the state, [~~which shall include~~] including a privately owned hospital whose inpatient admissions are predominantly for:

(A) rehabilitation;

(B) psychiatric care;

(C) chemical dependency services; or

(D) long-term acute care services[~~; and~~].

(b) "Private hospital" does not include a facility for residential [~~care or~~] treatment [~~facility~~] as defined in Section 62A-2-101.

[~~(8)~~] (12) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

(13) "Upper payment limit gap" means the difference between the private hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments, as determined in accordance with 42 C.F.R. Sec. 447.321.

Section 4. Section **26-36b-201** is amended to read:

26-36b-201. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of CMS approval of:

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

(ii) the assessment under this chapter;

(b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and

(c) in accordance with Section 26-36b-202.

(2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and

payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26-36b-210 have been paid.

(3) The first quarterly payment [~~shall not be~~] is not due until at least three months after the earlier of the effective [~~date~~] dates of the coverage provided through:

(a) the health coverage improvement program [~~waiver under Section 26-18-411.~~]; or

(b) the Medicaid waiver expansion.

Section 5. Section **26-36b-202** is amended to read:

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

(1) The collecting agent for the assessment imposed under Section 26-36b-201 is the department.

(2) The department is vested with the administration and enforcement of this chapter, [~~including the right to adopt administrative~~] and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

[~~(a) implement and enforce the provisions of this chapter;~~]

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this chapter;

(b) audit records of a facility that:

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

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

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

(2) The department shall:

(a) administer the assessment in this [~~part separate~~] chapter separately from the assessment in Chapter 36a, Hospital Provider Assessment Act; and

(b) deposit assessments collected under this chapter into the Medicaid Expansion Fund created by Section 26-36b-208.

Section 6. Section **26-36b-203** is amended to read:

26-36b-203. Quarterly notice.

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

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

Section 7. Section **26-36b-204** is amended to read:

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

[~~(1) For purposes of this section, "hospital share":~~]

(1) The hospital share is:

(a) [~~means~~] 45% of the state's net cost of[~~:(i)~~] the health coverage improvement program [~~Medicaid waiver under Section 26-18-411;(ii)~~], including Medicaid coverage for individuals with dependent children up to the federal poverty level designated under Section 26-18-411; [~~and~~]

[~~(iii) the UPL gap, as that term is defined in Section 26-36b-210;~~]

[~~(b) for the hospital share of the additional coverage under Section 26-18-411,~~]

(b) if the waiver for the Medicaid waiver expansion is approved, $11,900,000; and

(c) 45% of the state's net cost of the upper payment limit gap.

(2) (a) The hospital share is capped at no more than $13,600,000 annually, consisting of:

(i) an $11,900,000 cap [~~on the hospital's share~~] for the programs specified in Subsections (1)(a)[~~(i) and (ii)~~] and (b); and

(ii) a $1,700,000 cap for the program specified in Subsection (1)[~~(a)(iii);~~](c).

[~~(c) for the cap specified in Subsection (1)(b), shall be prorated~~]

(b) The department shall prorate the cap described in Subsection (2)(a) in any year in which at least one of the programs specified in Subsection (1)[~~(a)~~] are not in effect for the full fiscal year[~~; and~~].

[~~(d) if the Medicaid program expands in a manner that is greater than the expansion described in Section 26-18-411, is capped at 33% of the state's share of the cost of the~~

~~expansion that is in addition to the program described in Section 26-18-411.~~]

[~~(2) The assessment for the private hospital share under Subsection (1) shall be:~~]

(3) Private hospitals shall be assessed under this chapter for:

(a) 69% of the portion of the hospital share specified in Subsections (1)(a)[~~(i) and (ii)~~] and (b); and

(b) 100% of the portion of the hospital share specified in Subsection (1)[~~(a)(iii)~~](c).

[~~(3)~~] (4) (a) The department shall, on or before October 15, 2017, and on or before October 15 of each subsequent year [~~thereafter~~], produce a report that calculates the state's net cost of the programs described in Subsections (1)(a)[~~(i) and (ii)~~] and (b) that are in effect for that year.

(b) If the assessment collected in the previous fiscal year is above or below the [~~private hospital's share of the state's net cost as specified in Subsection (2),~~] hospital share for private hospitals for the previous fiscal year, the underpayment or overpayment of the assessment by the private hospitals shall be applied to the fiscal year in which the report [~~was~~] is issued.

[~~(4)~~] (5) A Medicaid accountable care organization shall, on or before October 15 of each year, report to the department the following data from the prior state fiscal year for each private hospital, state teaching hospital, and non-state government hospital provider that the Medicaid accountable care organization contracts with:

(a) for the traditional Medicaid population[~~, for each private hospital, state teaching hospital, and non-state government hospital provider~~]:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments; and

[~~(b) for the Medicaid population newly eligible under Subsection 26-18-411, for each private hospital, state teaching hospital, and non-state government hospital provider:~~]

(b) if the Medicaid accountable care organization enrolls any individuals in the health coverage improvement program or the Medicaid waiver expansion, for the population newly

eligible for either program:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

(6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide details surrounding specific content and format for the reporting by the Medicaid accountable care organization.

Section 8. Section **26-36b-205** is amended to read:

26-36b-205. Calculation of assessment.

(1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a quarterly basis for each private hospital in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and 60 residents shall pay an assessment rate [~~2.50~~] 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate [~~shall be determined using the total number of hospital discharges for assessed private hospitals, the percentages in Subsection 26-36b-204(2), and rule adopted by the department.~~] described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, described in Subsection 26-36b-204(1), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this chapter.

[~~(d)~~] (e) Any quarterly changes to the uniform assessment rate shall be applied

uniformly to all assessed private hospitals.

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

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

[~~(i)~~] (a) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2013, and June 30, 2014; and

[~~(ii)~~] (b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

[~~(b)~~] (3) (a) If a hospital's fiscal year Medicare cost report is not contained in the [~~Centers for Medicare and Medicaid Services'~~] CMS Healthcare Cost Report Information System file:

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

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

[~~(c)~~] (b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection [~~(2)(c)(i)~~] (3)(b)(i); and

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

[~~(3)~~] (4) Except as provided in Subsection [~~(4)~~] (5), if a hospital is owned by an organization that owns more than one hospital in the state:

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

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

[~~(4) Notwithstanding the requirement of Subsection (3), if~~]

(5) If multiple hospitals use the same Medicaid provider number:

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

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

Section 9. Section **26-36b-206** is amended to read:

26-36b-206. State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) [~~A~~] The state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund created in Section 26-36b-208, in accordance with this section.

(2) The [~~intergovernmental transfer shall be paid~~] hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of CMS approval of:

(a) the health improvement program waiver under Section 26-18-411; or

(b) the assessment for private hospitals in this chapter[~~; and~~].

[~~(c) the intergovernmental transfer in this section.~~]

(3) The intergovernmental transfer [~~shall be paid in an amount divided~~] is apportioned as follows:

(a) the state teaching hospital is responsible for:

(i) 30% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a)[~~(i) and (ii)~~] and (b); and

(ii) 0% of the hospital share specified in Subsection 26-36b-204(1)[~~(a)(iii)~~](c); and

(b) non-state government hospitals are responsible for:

(i) 1% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a)[~~(i) and (ii)~~] and (b); and

(ii) 0% of the hospital share specified in Subsection 26-36b-204(1)[~~(a)(iii)~~](c).

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the [~~percentages~~] amounts designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

Section 10. Section **26-36b-207** is amended to read:

26-36b-207. Penalties and interest.

(1) A hospital that fails to pay [~~any~~] a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this chapter, within the time required by this chapter, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer[~~, and interest established by the department~~].

[~~(2) (a) Consistent with Subsection (2)(b), the department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish reasonable penalties and interest for the violations described in Subsection (1).~~]

[~~(b)~~] (2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:

[~~(i)~~] (a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

[~~(ii)~~] (b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)[~~(b)(i)~~](a) are paid in full, an additional 5% penalty on:

[~~(A)~~] (i) any unpaid quarterly assessment or intergovernmental transfer; and

[~~(B)~~] (ii) any unpaid penalty assessment.

[~~(c)~~] (3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this chapter.

Section 11. Section **26-36b-208** is amended to read:

26-36b-208. Medicaid Expansion Fund.

(1) There is created an expendable special revenue fund known as the Medicaid Expansion Fund.

(2) The fund consists of:

(a) assessments collected under this chapter;

(b) intergovernmental transfers under Section 26-36b-206;

(c) savings attributable to the health coverage improvement program [~~under Section 26-18-411~~] as determined by the department;

(d) savings attributable to the Medicaid waiver expansion as determined by the department;

[~~(d)~~] (e) savings attributable to the inclusion of psychotropic drugs on the preferred drug list under Subsection 26-18-2.4(3) as determined by the department;

[~~(e)~~] (f) savings attributable to the services provided by the Public Employees' Health Plan under Subsection 49-20-401(1)(u);

[~~(f)~~] (g) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources; [~~and~~]

(h) interest earned on money in the fund; and

[~~(g)~~] (i) additional amounts as appropriated by the Legislature.

(3) (a) The fund shall earn interest.

(b) All interest earned on fund money shall be deposited into the fund.

(4) (a) A state agency administering the provisions of this chapter may use money from the fund to pay the costs [~~of~~], not otherwise paid for with federal funds or other revenue sources, of:

(i) the health coverage improvement [~~Medicaid waiver under Section 26-18-411, and~~] program;

(ii) the Medicaid waiver expansion; and

(iii) the outpatient [~~UPL~~] upper payment limit supplemental payments under Section

26-36b-210[~~, not otherwise paid for with federal funds or other revenue sources, except that no~~].

(b) A state agency administering the provisions of this chapter may not use:

(i) funds described in Subsection (2)(b) [~~may be used~~] to pay the cost of private outpatient [~~UPL~~] upper payment limit supplemental payments[~~.~~]; or

[~~(b)~~] (ii) [~~Money~~] money in the fund [~~may not be used for any other~~] for any purpose not described in Subsection (4)(a).

Section 12. Section **26-36b-209** is amended to read:

26-36b-209. Hospital reimbursement.

(1) [~~The~~] If the health coverage improvement program or the Medicaid waiver expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include, in a contract [~~with a Medicaid accountable care organization~~] to provide benefits under the health coverage improvement program or the Medicaid waiver expansion, a requirement that the Medicaid accountable care organization reimburse hospitals in the accountable care organization's provider network[~~,~~] at no less than the Medicaid fee-for-service rate.

(2) If the health coverage improvement program or the Medicaid waiver expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service [~~rates~~] rate.

Section 13. Section **26-36b-210** is amended to read:

26-36b-210. Outpatient upper payment limit supplemental payments.

[~~(1) For purposes of this section, "UPL gap" means the difference between the private hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments, as determined in accordance with 42 C.F.R. 447.321.~~]

[~~(2)~~] (1) Beginning on the effective date of the assessment imposed under this chapter, and for each subsequent fiscal year [~~thereafter~~], the department shall implement an outpatient

upper payment limit program for private hospitals that shall supplement the reimbursement to private hospitals in accordance with Subsection [~~(3)~~] (2).

[~~(3)~~] (2) The division shall ensure that supplemental payment to Utah private hospitals under Subsection [~~(2) shall~~] (1):

(a) does not exceed the positive [~~UPL~~] upper payment limit gap; and

(b) [~~be~~] is allocated based on the Medicaid state plan.

[~~(4)~~] (3) The department shall use the same outpatient data [~~used to calculate the UPL gap under Subsection (1) shall be the same outpatient data used~~] to allocate the payments under Subsection [~~(3)~~] (2) and to calculate the upper payment limit gap.

[~~(5)~~] (4) The supplemental payments to private hospitals under Subsection [~~(2) shall be~~] (1) are payable for outpatient hospital services provided on or after the later of:

(a) July 1, 2016;

(b) the effective date of the Medicaid state plan amendment necessary to implement the payments under this section; or

(c) the effective date of the coverage provided through the health coverage improvement program waiver [~~under Section 26-18-411~~].

Section 14. Section **26-36b-211** is amended to read:

26-36b-211. Suspension of assessment.

(1) The [~~repeal of the~~] department shall suspend the assessment imposed by this chapter [~~shall occur upon the certification by the executive director of the department that the sooner of the following has occurred~~] when the executive director certifies that:

[~~(a) the effective date of any action by Congress that would disqualify~~]

(a) action by Congress is in effect that disqualifies the assessment imposed by this chapter from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(b) [~~the effective date of any~~] a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, [~~that has the effect of~~] is in effect that:

(i) [~~disqualifying~~] disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) [~~creating~~] creates for any reason a failure of the state to use the assessments for at least one of the Medicaid [~~program as~~] programs described in this chapter; or

(c) [~~the effective date of~~] a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015[~~; and~~].

[~~(d) the sunset of this chapter in accordance with Section 63I-1-226.~~]

[~~(2) If the assessment is repealed under Subsection (1), money in the fund that was derived from assessments imposed by this chapter, before the determination made under Subsection (1), shall be disbursed under Section 26-36b-207 to the extent federal matching is not reduced due to the impermissibility of the assessments. Any funds remaining in the special revenue fund shall be refunded to the hospitals in proportion to the amount paid by each hospital.~~]

(2) If the assessment is suspended under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this chapter;

(b) the division shall disburse money in the Medicaid Expansion Fund in accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

(c) the division shall refund any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this chapter to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years; and

(d) the division shall deposit any money remaining in the Medicaid Expansion Fund after the disbursements described in Subsections (2)(b) and (c) into the General Fund by the end of the fiscal year that the assessment is suspended.

Section 15. Section **26-36c-101** is enacted to read:

CHAPTER 36c. MEDICAID EXPANSION HOSPITAL ASSESSMENT ACT

Part 1. General Provisions

26-36c-101. Title.

This chapter is known as the "Medicaid Expansion Hospital Assessment Act."

Section 16. Section **26-36c-102** is enacted to read:

26-36c-102. Definitions.

As used in this chapter:

(1) "Assessment" means the Medicaid expansion hospital assessment established by this chapter.

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

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

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.

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

(5) "Hospital share" means the hospital share described in Section 26-36c-203.

(6) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26-18-405.

(7) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26-36b-208.

(8) "Medicaid waiver expansion" means the same as that term is defined in Section 26-18-415.

(9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

(10) (a) "Non-state government hospital" means a hospital owned by a non-state government entity.

(b) "Non-state government hospital" does not include:

(i) the Utah State Hospital; or

(ii) a hospital owned by the federal government, including the Veterans Administration Hospital.

(11) (a) "Private hospital" means:

(i) a privately owned general acute hospital operating in the state as defined in Section 26-21-2; or

(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital for which inpatient admissions are predominantly:

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services.

(b) "Private hospital" does not include a facility for residential treatment as defined in Section 62A-2-101.

(12) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

Section 17. Section **26-36c-103** is enacted to read:

26-36c-103. Application.

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

(a) state law;

(b) ad valorem property tax requirement;

(c) sales or use tax requirement; or

(d) other requirements imposed by taxes, fees, or assessments, whether imposed or

sought to be imposed, by the state or any political subdivision of the state.

(2) A hospital paying an assessment under this chapter may include the assessment as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

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

(a) license a hospital for revenue;

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

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

Section 18. Section **26-36c-201** is enacted to read:

Part 2. Assessment and Collection

26-36c-201. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of CMS approval of:

(i) the waiver for the Medicaid waiver expansion; and

(ii) the assessment under this chapter;

(b) in the amount designated in Sections 26-36c-204 and 26-36c-205; and

(c) in accordance with Section 26-36c-202.

(2) Subject to Subsection 26-36c-202(4), the assessment imposed by this chapter is due and payable on the last day of each quarter.

(3) The first quarterly payment is not due until at least three months after the effective date of the coverage provided through the Medicaid waiver expansion.

Section 19. Section **26-36c-202** is enacted to read:

26-36c-202. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The department shall act as the collecting agent for the assessment imposed under Section 26-36c-201.

(2) The department shall administer and enforce the provisions of this chapter, and may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this chapter;

(b) audit records of a facility that:

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

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

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

(3) The department shall:

(a) administer the assessment in this part separately from the assessments in Chapter 36a, Hospital Provider Assessment Act, and Chapter 36b, Inpatient Hospital Assessment Act; and

(b) deposit assessments collected under this chapter into the Medicaid Expansion Fund.

(4) (a) Hospitals shall pay the quarterly assessments imposed by this chapter to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

(b) The department may make rules creating requirements to allow the time for paying the assessment to be extended.

Section 20. Section **26-36c-203** is enacted to read:

26-36c-203. Hospital share.

(1) The hospital share is 100% of the state's net cost of the Medicaid waiver expansion, after deducting appropriate offsets and savings expected as a result of implementing the Medicaid waiver expansion, including savings from:

(a) the Primary Care Network program;

(b) the health coverage improvement program, as defined in Section 26-18-411;

(c) the state portion of inpatient prison medical coverage;

(d) behavioral health coverage; and

(e) county contributions to the non-federal share of Medicaid expenditures.

(2) (a) The hospital share is capped at no more than $25,000,000 annually.

(b) The division shall prorate the cap specified in Subsection (2)(a) in any year in which the Medicaid waiver expansion is not in effect for the full fiscal year.

Section 21. Section **26-36c-204** is enacted to read:

26-36c-204. Hospital financing of Medicaid waiver expansion.

(1) Private hospitals shall be assessed under this chapter for the portion of the hospital share described in Section 26-36c-209.

(2) The department shall, on or before October 15, 2019, and on or before October 15 of each subsequent year, produce a report that calculates the state's net cost of the Medicaid waiver expansion.

(3) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the division shall apply the underpayment or overpayment of the assessment by the private hospitals to the fiscal year in which the report is issued.

Section 22. Section **26-36c-205** is enacted to read:

26-36c-205. Calculation of assessment.

(1) (a) Except as provided in Subsection (1)(b), each private hospital shall pay an annual assessment due on the last day of each quarter in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and more than 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection 26-36c-204(1), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may make rules in accordance with Title 63G, Chapter 3, Utah

Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this chapter.

(e) The division shall apply any quarterly changes to the uniform assessment rate uniformly to all assessed private hospitals.

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

(a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

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

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

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

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

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(c)(i); and

(iii) if the hospital fails to submit discharge information, the division shall audit the hospital's records and may impose a penalty equal to 5% of the calculated assessment.

(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the division shall calculate the assessment for each hospital separately; and

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

(5) If multiple hospitals use the same Medicaid provider number:

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

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

Section 23. Section **26-36c-206** is enacted to read:

26-36c-206. State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) A state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund, in accordance with this section.

(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of CMS approval of:

(a) the waiver for the Medicaid waiver expansion; or

(b) the assessment for private hospitals in this chapter.

(3) The intergovernmental transfer is apportioned between the non-state government hospitals as follows:

(a) the state teaching hospital shall pay for the portion of the hospital share described in Section 26-36c-209; and

(b) non-state government hospitals shall pay for the portion of the hospital share described in Section 26-36c-209.

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the amounts designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

Section 24. Section **26-36c-207** is enacted to read:

26-36c-207. Penalties.

(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this chapter, within the time required by this chapter, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.

(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:

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

(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

(i) any unpaid quarterly assessment or intergovernmental transfer; and

(ii) any unpaid penalty assessment.

(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive or reduce any of the penalties imposed under this chapter.

Section 25. Section **26-36c-208** is enacted to read:

26-36c-208. Hospital reimbursement.

(1) If the Medicaid waiver expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include in a contract to provide benefits under the Medicaid waiver expansion a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

(2) If the Medicaid waiver expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits the department or a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

Section 26. Section **26-36c-209** is enacted to read:

26-36c-209. Hospital financing of the hospital share.

(1) For the first two full fiscal years that the assessment is in effect, the department shall:

(a) assess private hospitals under this chapter for 69% of the hospital share for the

Medicaid waiver expansion;

(b) require the state teaching hospital to make an intergovernmental transfer under this chapter for 30% of the hospital share for the Medicaid waiver expansion; and

(c) require non-state government hospitals to make an intergovernmental transfer under this chapter for 1% of the hospital share for the Medicaid waiver expansion.

(2) (a) At the beginning of the third full fiscal year that the assessment is in effect, and at the beginning of each subsequent fiscal year, the department may set a different percentage share for private hospitals, the state teaching hospital, and non-state government hospitals by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, with input from private hospitals and private teaching hospitals.

(b) If the department does not set a different percentage share under Subsection (2)(a), the percentage shares in Subsection (1) shall apply.

Section 27. Section **26-36c-210** is enacted to read:

26-36c-210. Suspension of assessment.

(1) The department shall suspend the assessment imposed by this chapter when the executive director certifies that:

(a) action by Congress is in effect that disqualifies the assessment imposed by this chapter from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(b) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(i) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this chapter; or

(c) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015.

(2) If the assessment is suspended under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this chapter;

(b) the division shall disburse money in the Medicaid Expansion Fund that was derived from assessments imposed by this chapter in accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

(c) the division shall refund any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this chapter to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years.

Section 28. Section **63I-1-226** is amended to read:

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

(1) Section 26-1-40 is repealed July 1, 2019.

(2) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July 1, 2025.

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

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

(5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2019.

(6) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, [~~2021~~] 2024.

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

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

(7) Title 26, Chapter 36c, Medicaid Expansion Hospital Assessment Act, is repealed July 1, 2024.

[~~(9)~~] (8) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

Section 29. **Coordinating H.B. 472 with H.B. 14 -- Superseding technical and substantive amendments.**

If this H.B. 472 and H.B. 14, Substance Abuse Treatment Facility Patient Brokering, both pass and become law, it is the intent of the Legislature that the amendments to Section 26-36b-103 in this bill supersede the amendments to Section 26-36b-103 in H.B. 14, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.

Section 30. **Coordinating H.B. 472 with S.B. 125 -- Superseding technical and substantive amendments.**

If this H.B. 472 and S.B. 125, Child Welfare Amendments, both pass and become law, it is the intent of the Legislature that the amendments to Section 26-36b-103 in this bill supersede the amendments to Section 26-36b-103 in S.B. 125, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.