Hospital Quality Incentive Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Evan J. Vickers

House Sponsor: Steve Eliason

LONG TITLE

General Description:

This bill addresses provisions related to Medicaid hospital provider assessments and payment rates.

Highlighted Provisions:

This bill:

- addresses provisions related to the calculation of:
  - the Medicaid hospital provider assessment; and
  - the Medicaid accountable care organization rate structure to include certain quality incentive arrangements;
- permits funds from the Hospital Provider Assessment Expendable Revenue Fund to be used to support the implementation of provisions of this bill; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26B-1-316 (Effective 05/06/26), as last amended by Laws of Utah 2024, Chapter 284

26B-3-705 (Effective 05/06/26) (Repealed 07/01/28), as last amended by Laws of Utah 2024, Chapter 284

26B-3-707 (Effective 05/06/26) (Repealed 07/01/28), as last amended by Laws of Utah 2024, Chapter 284

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

Section 1. Section **26B-1-316** is amended to read:

26B-1-316 (Effective 05/06/26). Hospital Provider Assessment Expendable Revenue Fund.

(1) There is created an expendable special revenue fund known as the "Hospital Provider Assessment Expendable Revenue Fund."

(2) The fund shall consist of:

(a) the assessments collected by the department under Chapter 3, Part 7, Hospital Provider Assessment;

(b) any interest and penalties levied with the administration of Chapter 3, Part 7, Hospital Provider Assessment; and

(c) any other funds received as donations for the fund and appropriations from other sources.

(3) Money in the fund shall be used:

(a) to support capitated rates consistent with Subsection 26B-3-705(1)(d) for accountable care organizations as defined in Section 26B-3-701;

(b) to implement the quality strategies described in Subsection 26B-3-707(2), except that the amount under this Subsection (3)(b) may not exceed $211,300 in each fiscal year; [~~and~~]

(c) to implement Subsection 26B-3-707(1)(c), including monitoring Medicaid accountable care organizations' distribution of funds to hospitals, except that the amount under this Subsection (3)(c) may not exceed $200,000 in each fiscal year; and

[~~(c)~~] (d) to reimburse money collected by the division from a hospital, as defined in Section 26B-3-701, through a mistake made under Chapter 3, Part 7, Hospital Provider Assessment.

Section 2. Section **26B-3-705** is amended to read:

26B-3-705 (Effective 05/06/26) (Repealed 07/01/28). Calculation of assessment.

(1)(a) An annual assessment is payable on a quarterly basis for each hospital in an amount calculated at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) The uniform assessment rate shall be determined using the total number of hospital discharges for assessed hospitals divided into the total non-federal portion in an amount consistent with Section 26B-3-707 that is needed to support capitated rates and payments under 42 C.F.R. Sec. 438.6(b)(2) for Medicaid accountable care organizations for purposes of hospital services provided to Medicaid enrollees.

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

(d) The annual uniform assessment rate may not generate more than:

(i) $1,000,000 to offset Medicaid mandatory expenditures; and

(ii) the non-federal share to seed amounts needed to support capitated rates for Medicaid accountable care organizations as provided for in Subsection (1)(b).

(2)(a) For each state fiscal year, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the CMS Healthcare Cost Report Information System file. The hospital's discharge data is the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.

(b) If a hospital's fiscal year Medicare Cost Report is not contained in the 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) 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 its 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); 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) Except as provided in Subsection (4), 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 part.

(4) Notwithstanding the requirement of Subsection (3), 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 3. Section **26B-3-707** is amended to read:

26B-3-707 (Effective 05/06/26) (Repealed 07/01/28). Medicaid hospital adjustment under Medicaid accountable care organization rates.

(1) To preserve and improve access to hospital services, the division shall incorporate into the Medicaid accountable care organization rate structure calculation consistent with the certified actuarial rate range:

(a) $154,000,000 to be allocated toward the hospital inpatient directed payments for the Medicaid eligibility categories covered in Utah before January 1, 2019; [~~and~~]

(b) an amount equal to the difference between payments made to hospitals by Medicaid accountable care organizations for the Medicaid eligibility categories covered in Utah, based on submitted encounter data, and the maximum amount that could be paid for those services, to be used for directed payments to hospitals for inpatient and outpatient services[~~.~~] ; and

(c) up to the maximum amount under 42 C.F.R. Sec. 438.6(b)(2) quality incentive arrangements if Medicaid accountable care organizations distribute at least 90% of those funds to hospitals.

(2)(a) To preserve and improve the quality of inpatient and outpatient hospital services authorized under Subsection (1)(b), the division shall amend its quality strategies required by 42 C.F.R. Sec. 438.340 to include quality measures selected from the CMS hospital quality improvement programs.

(b) To better address the unique needs of rural and specialty hospitals, the division may adopt different quality standards for rural and specialty hospitals.

(c) The division shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt the selected quality measures and prescribe penalties for not meeting the quality standards that are established by the division by rule.

(d) The division shall apply the same quality measures and penalties under this Subsection (2) to new directed payments made to the University of Utah Hospital and Clinics.

Section 4. **Effective Date.**

This bill takes effect on May 6, 2026.