AccessUtah+ Proposal

Health Reform Task Force
October 6, 2015

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

Preferred Drug List

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

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

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

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

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

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

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

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

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

(i) 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)~~] (ii) 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)~~] (iii) 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)~~] (iv) 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 department's 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-psychotics, anti-depressants, anti-convulsant/mood [~~stabilizer~~] stabilizers, anti-anxiety drugs, attention deficit hyperactivity disorder stimulants, or sedative/hypnotics.

(iii) "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~~] by use of 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)(c), 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~~] a 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 who have undergone an organ transplant, the prescription for a particular immunosuppressive drug as written by [~~a~~] the health care provider meets the criteria of demonstrating to the [~~Department of Health~~] department a medical necessity for dispensing the prescribed immunosuppressive drug.

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

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

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

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

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

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

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

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

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

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

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

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

(1).

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

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

CHAPTER 18c ACCESSUTAH+

Part 1. General Provisions

26-18c-101. Title.

This chapter is known as "AccessUtah+".

26-18c-102. Definitions.

For purposes of this chapter:

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

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

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

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

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

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

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

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

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

(a) as determined by the department; and

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

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

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

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

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

Part 2. Duties and Authority of Department

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

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

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

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

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

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

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

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

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

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

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

Part 3. Description of AccessUtah+

26-18c-301. Medically frail individuals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Coverage under Subsection (1):

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

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

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

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

(a) may not:

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

(ii) provide non-emergent transportation; and

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

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

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

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

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

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

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

(a) limited by an open enrollment period; or

(b) applied retroactively from the date of enrollment.

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

(a) may not:

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

(ii) provide non-emergent transportation; and

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

26-18c-305. Keeping families together.

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

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

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

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

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

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

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

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

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

26-18c-306. Work Assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 4. Inpatient Hospital Services.

26-18c-401. Title.

This part is known as "Inpatient Hospital Services."

26-18c-402. Application.

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

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

(b) other applicable federal law;

(c) any state law;

(d) any ad valorem property taxes;

(e) any sales or use taxes; or

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

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

(3) This part 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.

26-18c-403. Definitions.

As used in this part:

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

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

(a) worksheet S-3 Part I, column 15, lines 12, 14, and 14.01 of the 2552-96 Medicare cost report or on 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 (2)(a) is no longer available.

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

(5) "Hospital":

(a) means a privately owned:

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

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

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services; and

(b) does not include:

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

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

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

(A) a state-owned teaching hospital; and

(B) the Utah State Hospital.

(6) "Medicare cost report" means CMS-2552-96 or CMS-2552-10, the cost report for electronic filing of hospitals.

26-18c-404. Assessment.

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

(a) in the amount designated in Section 26-18c-407; and

(b) in accordance with Section 26-18c-406.

(2) Subject to Section 26-18c-405, the assessment imposed by this part is due and payable on a quarterly basis.

26-18c-405. Collection of assessment -- Deposit of Revenue -- Rulemaking.

(1) The collecting agent for assessment imposed under Section 26-18c-404 is the department which is vested with the administration and enforcement of this part, including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

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

(b) audit records of a facility:

(i) that is subject to the assessment imposed by this part; 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 deposit assessments collected under this part in the expendable special revenue fund created in Section 26-18c-2003.

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

26-18c-406. Quarterly notice.

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.

26-18c-407. 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 for fiscal years beginning on or after:

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

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

(c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to all assessed 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, or the report's equivalent if the report is replaced in the future by CMS. The hospital's discharge data will be derived as follows:

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

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

(iii) 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 prior to the assessment fiscal year.

(b) 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.

(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 chapter.

(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.

Part 5. Outpatient Hospital Services.

26-18c-501. Title.

This part is known as "Outpatient Hospital Services."

26-18c-502. Application.

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

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

(b) other applicable federal law;

(c) any state law;

(d) any ad valorem property taxes;

(e) any sales or use taxes; or

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

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

(3) This part 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.

26-18c-503. Definitions.

As used in this part:

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

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

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

(4) "Hospital":

(a) means a privately owned:

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

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

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services; and

(b) does not include:

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

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

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

(A) a state-owned teaching hospital; and

(B) the Utah State Hospital.

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

26-18c-504. Assessment.

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

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

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

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

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

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

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

(b) audit records of a facility:

(i) that is subject to the assessment imposed by this part; 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 deposit assessments collected under this part in the expendable special revenue fund created in Section 26-18c-2003.

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

26-18c-506. Quarterly notice.

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.

26-18c-507. 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 dollar of reported cost, in accordance with this section.

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

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

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

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

(2) (a) For each state fiscal year, cost 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 cost data will be derived as follows:

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

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

ending between July 1, 2015, and June 30, 2016; and

(iii) 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 prior to the assessment fiscal year.

(b) 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.

(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 chapter.

(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.

Part 6. Physician Services.

26-18c-601. Title.

This part is known as "Physician Services."

26-18c-602. Definitions

As used in this part:

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

(i) a naturopathic physician;

(ii) a physician; or

(iii) a physician assistant.

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

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

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

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

26-18c-603. Tax.

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

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

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

Part 7. Home Health Care Services

26-18c-701. Title.

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

26-18c-702. Definitions

As used in this part:

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

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

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

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

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

26-18c-703. Tax.

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

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

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

Part 8. Outpatient Prescription Drugs.

26-18c-801. Title.

This part is known as "Outpatient Prescription Drugs."

26-18c-802. Definitions.

As used in this part:

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

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

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

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

(b) marketed, sold, or distributed with a labeler code, product code, trade name, trademark, or packaging, other than repackaging, different from the brand name drug.

(3) Alternative Definition: "Generic name drug" means any drug that is:

(a) a bioequivalent to a brand name drug in dosage form, safety, strength, and composition of active ingredients;

(b) marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging; and

(c) produced after the patent for the brand name drug expires.

(4) "Generic name pharmaceutical manufacturing company" means a pharmaceutical manufacturing company that produces generic name drugs.

(5) "Outpatient prescription drugs provider" means a brand name pharmaceutical manufacturing company, generic name pharmaceutical manufacturing company, pharmacy, or pharmacy benefit manager.

(6) "Outpatient prescription drugs services" means the sale of prescription drugs by an outpatient prescription drugs provider.

(7) (a) "Pharmaceutical manufacturing company" means a person that:

(i) produces, prepares, propagates, converts, or processes a drug, either directly or indirectly, by extraction from substances of natural origin or independently by means of chemical or biological synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling its container; and

(ii) promotes or markets the drugs.

(b) "Pharmaceutical manufacturing company" includes a brand name pharmaceutical manufacturing company and a generic name manufacturing company, as defined in this section.

(7) (a) Alternative Definition: "Pharmaceutical manufacturing company" means a person who performs substantially all of the following operations that are required to produce a brand name or generic name drug product:

(i) mixing;

(ii) granulating;

(iii) milling;

(iv) molding;

(v) lyophilizing;

(vi) tableting;

(vii) encapsulating;

(viii) coating;

(ix) sterilizing; and

(x) filling sterile, aerosol, or gaseous drugs into dispensing containers.

(b) "Pharmaceutical manufacturing company" includes a brand name pharmaceutical manufacturing company and a generic name manufacturing company, as defined in this section.

(8) "Pharmacy" means the same as that term is defined in Section 58-17b-102 and includes all classes of pharmacies licensed under Title 58, Chapter 17b, Part 3, Licensing.

(9) "Pharmacy benefit manager" means the same as that term is defined in Section 49-20-502.

26-18c-803. Tax.

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

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

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

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

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

Part 9. Health Care Coverage Premium Tax

26-18c-901. Title.

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

26-18c-902. Definitions.

As used in this part:

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

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

(i) a health benefit plan;

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

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

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

(i) dental;

(ii) vision;

(iii) income replacement;

(iv) accident;

(v) fixed indemnity;

(vi) long-term care insurance;

(vii) specified disease;

(viii) a Medicare plan or supplement;

(ix) federal employees health benefits;

(x) credit accident and health;

(xi) supplement to liability;

(xii) workers' compensation;

(xiii) automobile medical payment;

(xiv) no-fault automobile;

(xv) equivalent self-insurance;

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

Insurance Program Act; or

(xvii) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

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

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

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

26-18c-903. Calculation of tax.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 10. Ambulatory Surgical Center Services.

26-18c-1001. Title.

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

26-18c-1002. Definitions.

As used in this part:

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

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

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

26-18c-1003. Tax.

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

Part 11. Dental Services.

26-18c-1101. Title.

This part is known as "Dental Services."

26-18c-1102. Definitions.

As used in this part:

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

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

26-18c-1103. Tax.

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

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

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

Part 12. Podiatric Services.

26-18c-1201. Title.

This part is known as "Podiatric Services."

26-18c-1202. Definitions.

As used in this part:

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

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

26-18c-1203. Tax.

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

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

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

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

Part 13. Chiropractic Services.

26-18c-1301. Title.

This part is known as "Chiropractic Services."

26-18c-1302. Definitions.

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

26-18c-1303. Tax.

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

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

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

Part 14. Optometric Services.

26-18c-1401. Title.

This part is known as "Optometric Services."

26-18c-1402. Definitions.

As used in this part:

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

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

26-18c-1403. Tax.

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

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

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

Part 15. Psychological Services.

26-18c-1501. Title.

This part is known as "Psychological Services."

26-18c-1502. Definitions.

As used in this part:

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

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

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

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

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

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

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

(i) day treatment;

(ii) outpatient treatment;

(iii) recovery residence;

(iv) residential support;

(v) residential treatment;

(vi) social detoxification.

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

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

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

26-18c-1503. Tax.

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

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

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

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

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

Part 16. Therapist Services.

26-18c-1601. Title.

This part is known as "Therapist Services."

26-18c-1602. Definitions.

As used in this part:

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

(i) an audiologist,

(ii) an occupational therapist;

(iii) a physical therapist;

(iv) a respiratory care practitioner; or

(v) a speech language pathologist.

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

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

41, Speech-Language Pathology and Audiology Licensing Act.

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

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

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

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

26-18c-1603. Tax.

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

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

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

Part 17. Nursing Services

26-18c-1701. Title.

This part is known as "Nursing Services."

26-18c-1702. Definitions.

As used in this part:

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

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

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

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

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

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

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

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

26-18c-1703. Tax.

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

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

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

Part 18. Laboratory and X-Ray Services

26-18c-1801. Title.

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

26-18c-1802. Definitions.

As used in the part:

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

(a) is freestanding; and

(b) performs clinical laboratory services.

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

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

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

(a) clinical laboratory services; or

(b) x-ray services

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

(a) a clinical laboratory; or

(b) an x-ray service provider.

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

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

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

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

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

(a) is freestanding; and

(b) performs x-ray services.

26-18c-1803. Tax.

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

Part 19. Taxation and Collection

26-18c-1901. Title.

This part is known as "Taxation and Collection."

26-18c-1902. Definitions.

(1) As used in this part:

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

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

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

(d) "Service provider" means:

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

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

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

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

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

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

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

(e) "Services" means:

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

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

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

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

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

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

26-18c-1903. Tax imposed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26-18c-1904. Administration of tax.

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

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

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

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

26-18c-1906. Deposit of revenue.

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

26-18c-1907. Penalties and interest.

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

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

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

26-18c-1908. Application of apportionment.

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

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

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

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

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

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

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

(2) the denominator of the fraction is one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) separate accounting;

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

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

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

26-18c-2001. Title.

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

26-18c-2002. Definitions.

As used in this part,

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

department, adults enrolled in the Medicaid program during a fiscal year, but not under this chapter, whose enrollment is attributable to the implementation of UtahAccess+.

(2) "Insurer class" means the following three classes:

(a) individual comprehensive health care coverage insurers taxed under Section 26-18c-903(1)(a);

(b) medical stop loss insurers taxed under Section 26-18c-903(1)(b); and

(c) insurers issuing comprehensive health care coverage in this state that is not described in Subsections 26-18c-903(a) or (b), which are taxed under Section 26-18c-903(1)(c).

(3) "Insurer class factor" means the amount calculated by dividing insurer class payments by total Utah Access+ insurer payments.

(4) "Insurer class payments" means total payments made by the Medicaid program to an insurer class during the second preceding fiscal year to fund:

(a) AccessUtah+; and

(b) Medicaid program services and benefits to adults who were previously eligible but not enrolled.

(5) "Medical provider class" means the following 16 classes:

(a) persons assessed under Part 4, Inpatient Hospital Services;

(b) persons assessed under Part 5, Outpatient Hospital Services;

(c) persons assessed under Part 6, Physician Services;

(d) persons assessed under Part 7, Home Health Care Services;

(e) persons assessed under Part 8, Outpatient Prescription Drugs;

(f) persons assessed under Part 9, Managed Care Organizations;

(g) persons assessed under Part 10, Ambulatory Surgical Center Services;

(h) persons assessed under Part 11, Dental Services;

(i) persons assessed under Part 12, Podiatric Services;

(j) persons assessed under Part 13, Chiropractic Services;

(k) persons assessed under Part 14, Optometric Services;

(l) persons assessed under Part 15, Psychological Services;

(m) persons assessed under Part 16, Therapist Services;

(n) persons assessed under Part 17, Nursing Services;

(o) persons assessed under Part 18, Laboratory and X-Ray Services; and

(p) emergency ambulance service providers assessed under Section 26-37a-105.1;

(6) "Medical provider class factor" means the amount calculated by dividing medical provider class payments by total payments for UtahAccess+.

(7) "Medical provider class payments" means total payments made by the Medicaid program to a medical provider class during the second preceding fiscal year to fund:

(a) AccessUtah+; and

(b) Medicaid program services and benefits to adults who were previously eligible but not enrolled.

(8) "Ongoing General Fund savings" means the sum of the following savings:

(a) 13,000,000 ongoing General Fund savings to the Division of Substance Abuse and Mental Health within the Department of Human Services, which is attributable to the implementation of AccessUtah+;

(b) $1,700,000 ongoing General Fund savings, which is attributable to 2015 General Session H.B. 348, Criminal Justice Programs and Amendments; and

(c) preferred drug list savings for the immediately preceding fiscal year appropriated to the UtahAccess+ Fund under Subsection 26-18-2.4(4).

(9) "Outpatient prescription drugs provider class" means the following three classes:

(a) brand name pharmaceutical manufacturing companies taxed under Section 26-18c-1903(3);

(b) generic name pharmaceutical manufacturing companies taxed under Section 26-18c-1903(4); and

(c) pharmaceutical benefit managers taxed under Section 26-18c-1903(5).

(10) "Outpatient prescription drugs provider class factor" means the amount calculated by dividing outpatient prescription drugs provider class payments by total Utah Access+ payments for outpatient prescription drugs.

(11) "Outpatient prescription drugs provider class payments" means total payments made by the Medicaid program to an outpatient prescription drugs provider class during the second preceding fiscal year to fund:

(a) AccessUtah+; and

(b) Medicaid program services and benefits to adults who were previously eligible but not enrolled.

(12) "Preferred drug list savings" means the amount appropriated to the UtahAccess+ Fund under Subsection 26-18-2.4(4).

(13) "Projected total expenditures" means expenditures projected for a fiscal year by all state agencies administering the provisions of this chapter as determined via consensus by the Office of the Legislative Fiscal Analyst, Governor's Office of Planning and Budget, and the Department of Health.

(14) "Proportionate share of funding for insurers" means the amount calculated by multiplying the total assessment target by:

(a) 0.10; and

(b) the insurer class factor for the insurer class.

(15) "Proportionate share of funding for outpatient prescription drugs providers" means the amount calculated by

(16) "Proportionate share of total funding for the medical provider class" means the amount calculated by multiplying the total assessment target by:

(a) 0.90; and

(b) the medical provider class factor for the class.

(17) "State cost of UtahAccess+" means the amount calculated by multiplying 0.10 by the projected service total expenditures necessary to fund UtahAccess+ during a fiscal year.

(18) "Total tax target" means the amount calculated by making the following adjustments to the state cost of UtahAccess+:

(a) adding the cost of providing Medicaid program services and benefits to adults who were previously eligible but not enrolled; and

(b) subtracting ongoing General Fund savings.

(19) "Total UtahAccess+ insurer payments" means total payments made by the Medicaid

program to an insurer class during the second preceding fiscal year to fund:

(a) AccessUtah+; and

(b) Medicaid program services and benefits to adults who were previously eligible but not enrolled.

(20) "Total UtahAccess+ payments for outpatient prescription drugs" means total payments made by the Medicaid program to an outpatient prescription drugs provider class during the second preceding fiscal year to fund:

(a) AccessUtah+; and

(b) Medicaid program services and benefits to adults who were previously eligible but not enrolled.

(21) "Total payments for UtahAccess+" means the sum of all medical provider class payments.

26-18c-2003. UtahAccess+ Fund.

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

(2) The fund consists of:

(a) taxes and assessments collected under Parts 4 through 19 and Section 26-37a-105.1;

(b) savings attributable to UtahAccess+;

(c) preferred drug list savings appropriated to the fund under Subsection 26-18-2.4(4);

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

(e) 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 administering UtahAccess+ not otherwise paid for with federal funds or other revenue sources.

(b) Money in the fund may not be used for any other purpose.

26-18c-2004. Annual adjustment of assessments.

(1) For each fiscal year beginning on or after July 1, 2018, the taxes and assessments in Parts 4 through 19 of this chapter and Section 26-37a-105.1 shall be adjusted as follows:

(a) the taxes in Part 9, Health Care Coverage Premium Tax, shall be adjusted so that:

(i) the sum of taxes paid by insurers under the part during the fiscal year equals 10 percent of the total tax target; and

(ii) the sum of taxes paid by insurers within an insurer class equals the proportionate share of funding for insurers;

(b) the taxes and assessments in Parts 4 through 8 of this chapter, Parts 10 through 19 of this chapter, and Section 26-37a-105.1 shall be adjusted so that:

(i) the sum of taxes and assessments paid by providers within a medical provider class during the fiscal year equals the proportionate share of total funding for the medical provider class; and

(ii) (A) the sum of taxes and assessments paid by outpatient prescription drugs providers within an outpatient prescription drugs provider class equals the proportionate share of funding

for outpatient prescription drugs providers;

(B) the rate at which the gross receipts of a pharmacy benefit manager are taxed under Section 26-18c-1903(5) and the tax that a pharmacy benefit manager must pay under Section 26-18c-803(4) are adjusted by the same percentage.

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

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

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

26-18c-2005. Data collection.

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

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

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

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

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

26-37a-105.1. UtahAccess+ tax.

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

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

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