

Effective 5/10/2016

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

- (1) For purposes of this section, "hospital share":
 - (a) means 45% of the state's net cost of:
 - (i) the health coverage improvement program Medicaid waiver under Section 26-18-411;
 - (ii) 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, 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
 - (ii) a \$1,700,000 cap for the program specified in Subsection (1)(a)(iii);
 - (c) for the cap specified in Subsection (1)(b), shall be prorated in any year in which 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:
 - (a) 69% of the portion of the hospital share specified in Subsections (1)(a)(i) and (ii); and
 - (b) 100% of the portion of the hospital share specified in Subsection (1)(a)(iii).
- (3)
 - (a) The department shall, on or before October 15, 2017, and on or before October 15 of each year thereafter, produce a report that calculates the state's net cost of the programs described in Subsections (1)(a)(i) and (ii).
 - (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), 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 issued.
- (4) 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:
 - (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:
 - (i) hospital inpatient payments;
 - (ii) hospital inpatient discharges;
 - (iii) hospital inpatient days; and
 - (iv) hospital outpatient payments.

Enacted by Chapter 279, 2016 General Session