

**HOSPITAL PROVIDER ASSESSMENT AMENDMENTS**

2013 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Lyle W. Hillyard**

House Sponsor: Brad R. Wilson

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**LONG TITLE**

**General Description:**

This bill amends the Hospital Provider Assessment Act.

**Highlighted Provisions:**

This bill:

- ▶ defines terms;
- ▶ modifies the calculation of the annual assessment;
- ▶ modifies the manner in which a hospital's discharge data is derived;
- ▶ requires the Division of Health Care Financing of the Department of Health to incorporate \$154 million into the accountable care organization rate structure;
- ▶ grants rulemaking authority to the Department of Health over the penalties and interest assessed under the act;
- ▶ repeals the assessment on July 1, 2016; and
- ▶ makes technical changes.

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

If approved by two-thirds of all the members elected to each house, this bill takes effect on April 1, 2013.

**Utah Code Sections Affected:**

AMENDS:



- 28           **26-36a-103**, as enacted by Laws of Utah 2010, Chapter 179
- 29           **26-36a-202**, as enacted by Laws of Utah 2010, Chapter 179
- 30           **26-36a-203**, as last amended by Laws of Utah 2012, Chapter 348
- 31           **26-36a-204**, as enacted by Laws of Utah 2010, Chapter 179
- 32           **26-36a-205**, as last amended by Laws of Utah 2012, Chapter 348
- 33           **26-36a-206**, as enacted by Laws of Utah 2010, Chapter 179
- 34           **26-36a-207**, as enacted by Laws of Utah 2010, Chapter 179
- 35           **26-36a-208**, as last amended by Laws of Utah 2011, Chapter 118
- 36           **63I-1-226**, as last amended by Laws of Utah 2012, Chapters 171 and 328

37 REPEALS:

- 38           **26-36a-209**, as last amended by Laws of Utah 2012, Chapter 348



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

41           Section 1. Section **26-36a-103** is amended to read:

42           **26-36a-103. Definitions.**

43           As used in this chapter:

44           (1) "Assessment" means the Medicaid hospital provider assessment established by this  
45 chapter.

46           (2) "Discharges" means the number of total hospital discharges reported on worksheet  
47 S-3, column 15, lines 12, 14, and 14.01 of the Medicare Cost Report for the applicable  
48 assessment year.

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

50           (4) "Hospital":

51           (a) means a privately owned:

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

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

55           (A) rehabilitation;

56           (B) psychiatric;

57           (C) chemical dependency; or

58           (D) long-term acute care services; and

59 (b) does not include:

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

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

62 Hospital; or

63 [~~(iii) a Shriners hospital that does not charge for its services; or~~]

64 [~~(iv)~~] (iii) a hospital that is owned by the state government, a state agency, or a political

65 subdivision of the state, including:

66 (A) a state-owned teaching hospital; and

67 (B) the Utah State Hospital.

68 [~~(5) "Low volume select access hospital" means a hospital that furnished inpatient~~

69 ~~hospital services during fiscal year 2008 to less than 300 Medicaid cases under the select~~

70 ~~access program.]~~

71 [(6)] (5) "Medicare cost report" means CMS-2552-96 or CMS-2552-10, the cost report

72 for electronic filing of hospitals.

73 [(7) "Select access cases" means the number of hospital inpatient cases related to

74 ~~individuals enrolled in the state's select access program for 2008.]~~

75 [(8)] (6) "State plan amendment" means a change or update to the state Medicaid plan.

76 [(9) "Upper payment limit" means the maximum ceiling imposed by federal regulation

77 ~~on a hospital Medicaid reimbursement for inpatient services under 42 C.F.R. Sec. 447.272.]~~

78 [(10) "Upper payment limit gap":]

79 [(a) means the difference between:]

80 [(i) the inpatient hospital upper payment limit for hospitals; and]

81 [(ii) Medicaid payments for inpatient hospital services not financed using hospital

82 ~~assessments paid by all hospitals;]~~

83 [(b) shall be calculated separately for hospital inpatient services; and]

84 [(c) does not include Medicaid disproportionate share payments as part of the

85 ~~calculation for the upper payment limit gap.]~~

86 (7) "Accountable care organization" means a managed care organization, as defined in

87 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section

88 26-18-405.

89 Section 2. Section **26-36a-202** is amended to read:

90 **26-36a-202. Assessment, collection, and payment of hospital provider assessment.**

91 (1) A uniform, broad based, assessment is imposed on each hospital as defined in  
92 Subsection 26-36a-103(4)(a):

93 (a) in the amount designated in Section 26-36a-203; and

94 (b) in accordance with Section 26-36a-204~~[-beginning when the division has obtained~~  
95 ~~approval from the Center for Medicare and Medicaid Services and provided notice of the~~  
96 ~~assessment to the hospital].~~

97 (2) (a) The assessment imposed by this chapter is due and payable on a quarterly basis  
98 in accordance with Section 26-36a-204.

99 (b) The collecting agent for this assessment is the department which is vested with the  
100 administration and enforcement of this chapter, including the right to adopt administrative rules  
101 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

102 (i) implement and enforce the provisions of this act; and

103 (ii) audit records of a facility:

104 (A) that is subject to the assessment imposed by this chapter; and

105 (B) does not file a Medicare cost report.

106 (c) The department shall forward proceeds from the assessment imposed by this  
107 chapter to the state treasurer for deposit in the restricted special revenue fund as specified in  
108 Section 26-36a-207.

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

110 Section 3. Section **26-36a-203** is amended to read:

111 **26-36a-203. Calculation of assessment.**

112 ~~[(1) The division shall calculate the inpatient upper payment limit gap for hospitals for~~  
113 ~~each state fiscal year.]~~

114 ~~[(2)]~~ (1) (a) An annual assessment is payable on a quarterly basis for each hospital in  
115 an amount calculated at a uniform assessment rate for each hospital discharge, in accordance  
116 with this section.

117 (b) The uniform assessment rate shall be determined using the total number of hospital  
118 discharges for assessed hospitals divided into the total nonfederal portion ~~[of the upper~~  
119 ~~payment limit gap]~~ in an amount equal to the \$154 million that is needed to support capitated  
120 rates for accountable care organizations for purposes of hospital services provided to Medicaid

121 enrollees.

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

124 (d) ~~[(i) Except as provided in Subsection (2)(d)(ii), the]~~ The annual uniform  
125 assessment rate may not generate more than ~~[the non-federal share of the annual upper payment~~  
126 ~~limit gap for the fiscal year.];~~

127 ~~[(ii) For fiscal years 2011-12 and 2012-13 the department may generate an additional~~  
128 ~~amount from the assessment imposed under Subsection (2)(d)(i) in the amount of:]~~

129 ~~[(A)]~~ (i) \$1,000,000 to offset Medicaid mandatory expenditures; and

130 ~~[(B)]~~ (ii) the nonfederal share to seed amounts needed to support capitated rates for  
131 accountable care organizations as provided for in Section (1)(b).

132 ~~[(3)(a) For state fiscal years 2010 and 2011, discharges shall be determined using the~~  
133 ~~data from each hospital's Medicare Cost Report contained in the Centers for Medicare and~~  
134 ~~Medicaid Services' Healthcare Cost Report Information System file as of April 1, 2009, for~~  
135 ~~hospital fiscal years ending between October 1, 2007, and September 30, 2008.];~~

136 ~~[(b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for~~  
137 ~~Medicare and Medicaid Services' Healthcare Cost Report Information System file dated March~~  
138 ~~31, 2009.];~~

139 ~~[(i) the hospital shall submit to the division a copy of the hospital's Medicare Cost~~  
140 ~~Report with a fiscal year end between October 1, 2007, and September 30, 2008; and]~~

141 ~~[(ii) the division shall determine the hospital's discharges from the information~~  
142 ~~submitted under Subsection (3)(b)(i).];~~

143 ~~[(c) If a hospital started operations after the due date for a 2007 Medicare Cost Report:]~~

144 ~~[(i) the hospital shall submit to the division a copy of the hospital's most recent~~  
145 ~~complete year Medicare Cost Report; and]~~

146 ~~[(ii) the division shall determine the hospital's discharges from the information~~  
147 ~~submitted under Subsection (3)(c)(i).];~~

148 ~~[(d) If a hospital is not certified by the Medicare program and is not required to file a~~  
149 ~~Medicare Cost Report:]~~

150 ~~[(i) the hospital shall submit to the division its applicable fiscal year discharges with~~  
151 ~~supporting documentation;]~~

152 ~~[(ii) the division shall determine the hospital's discharges from the information~~  
153 ~~submitted under Subsection (3)(d)(i); and]~~

154 ~~[(iii) the failure to submit discharge information under Subsections (3)(d)(i) and (ii)~~  
155 ~~shall result in an audit of the hospital's records by the department and the imposition of a~~  
156 ~~penalty equal to 5% of the calculated assessment.]~~

157 ~~[(4)]~~ (2) (a) For each state fiscal year ~~[2012 and 2013]~~, discharges shall be determined  
158 using the data from each hospital's Medicare Cost Report contained in the Centers for Medicare  
159 and Medicaid Services' Healthcare Cost Report Information System file ~~[as of:]~~. The hospital's  
160 discharge data will be derived as follows:

161 ~~[(i) for state fiscal year 2012, September 30, 2010, for hospital fiscal years ending~~  
162 ~~between October 1, 2008, and September 30, 2009; and]~~

163 ~~[(ii) for state fiscal year 2013, September 30, 2011, for hospital fiscal years ending~~  
164 ~~between October 1, 2009, and September 30, 2010.]~~

165 (i) for state fiscal year 2013, the hospital's cost report data for the hospital's fiscal year  
166 ending between July 1, 2009, and June 30, 2010;

167 (ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year  
168 ending between July 1, 2010, and June 30, 2011;

169 (iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year  
170 ending between July 1, 2011, and June 30, 2012; and

171 (iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year  
172 ending between July 1, 2012, and June 30, 2013.

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

175 (i) the hospital shall submit to the division a copy of the hospital's Medicare Cost  
176 Report applicable to the assessment year; and

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

178 (c) If a hospital is not certified by the Medicare program and is not required to file a  
179 Medicare Cost Report:

180 (i) the hospital shall submit to the division its applicable fiscal year discharges with  
181 supporting documentation;

182 (ii) the division shall determine the hospital's discharges from the information

183 submitted under Subsection ~~[(4)]~~ (2)(c)(i); and

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

186 ~~[(5)]~~ (3) Except as provided in Subsection ~~[(6)]~~ (4), if a hospital is owned by an  
187 organization that owns more than one hospital in the state:

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

189 and

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

191 ~~[(6)]~~ (4) Notwithstanding the requirement of Subsection ~~[(5)]~~ (3), if multiple hospitals  
192 use the same Medicaid provider number:

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

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

196 ~~[(7)(a) The assessment formula imposed by this section, and the inpatient access  
197 payments under Section 26-36a-205, shall be adjusted in accordance with Subsection (7)(b) if a  
198 hospital, for any reason, does not meet the definition of a hospital subject to the assessment  
199 under Section 26-36a-103 for the entire fiscal year.]~~

200 ~~[(b) The department shall adjust the assessment payable to the department under this  
201 chapter for a hospital that is not subject to the assessment for an entire fiscal year by  
202 multiplying the annual assessment calculated under Subsection (3) or (4) by a fraction, the  
203 numerator of which is the number of days during the year that the hospital operated, and the  
204 denominator of which is 365.]~~

205 ~~[(c) A hospital described in Subsection (7)(a):]~~

206 ~~[(i) that is ceasing to operate in the state, shall pay any assessment owed to the  
207 department immediately upon ceasing to operate in the state; and]~~

208 ~~[(ii) shall receive Medicaid inpatient hospital access payments under Section  
209 26-36a-205 for the state fiscal year, adjusted using the same formula described in Subsection  
210 (7)(b):]~~

211 ~~[(8) A hospital that is subject to payment of the assessment at the beginning of a state  
212 fiscal year, but during the state fiscal year experiences a change in status so that it no longer  
213 falls under the definition of a hospital subject to the assessment in Section 26-36a-204, shall:]~~

214 ~~[(a) not be required to pay the hospital assessment beginning on the date established by~~  
215 ~~the department by administrative rule; and]~~

216 ~~[(b) not be entitled to Medicaid inpatient hospital access payments under Section~~  
217 ~~26-36a-205 on the date established by the department by administrative rule.]~~

218 Section 4. Section **26-36a-204** is amended to read:

219 **26-36a-204. Quarterly notice -- Collection.**

220 ~~[(1) (a) The division shall submit to the Center for Medicare and Medicaid Services:]~~

221 ~~[(i) the payment methodology for the assessment imposed by this chapter; and]~~

222 ~~[(ii) if necessary, a waiver under 42 C.F.R. Sec. 433.68:]~~

223 ~~[(b) When the division receives notice of approval of the assessment and access~~  
224 ~~payments under this chapter from the Center for Medicare and Medicaid Services, the division~~  
225 ~~shall, within 45 days of the notice from the Center for Medicare and Medicaid Services,~~  
226 ~~provide a hospital that is subject to the assessment notice of:]~~

227 ~~[(i) the approval of the assessment methodology from the Center for Medicare and~~  
228 ~~Medicaid Services;]~~

229 ~~[(ii) the assessment rate;]~~

230 ~~[(iii) the hospital's discharges subject to the assessment; and]~~

231 ~~[(iv) the assessment amount owed by the hospital for the applicable fiscal year.]~~

232 ~~[(2) The initial quarterly installments of the assessment imposed by this chapter are due~~  
233 ~~and payable if:]~~

234 ~~[(a) the division has provided notice of the annual assessment under Subsection (1);~~  
235 ~~and]~~

236 ~~[(b) the division has made all the quarterly installments of the Medicaid inpatient~~  
237 ~~hospital access payments that were otherwise due under Section 26-36a-205, consistent with~~  
238 ~~the effective date of the approved state plan amendment.]~~

239 ~~[(3) After the initial quarterly installments of the Medicaid inpatient hospital access~~  
240 ~~payments are made by the division, a hospital shall pay to the division the initial quarterly~~  
241 ~~assessments imposed by this chapter within 10 business days. Subsequent quarterly]~~

242 Quarterly assessments imposed by this chapter shall be paid to the division within [10]  
243 15 business days after the [hospital receives its Medicaid inpatient hospital access payment due  
244 for the applicable quarter under Section 26-36a-205] date that appears on the invoice issued by



245 the division.

246 Section 5. Section **26-36a-205** is amended to read:

247 **26-36a-205. Medicaid hospital adjustment under accountable care organization**  
248 **rates.**

249 [(†)] To preserve and improve access to [hospitals] hospital services, the division shall  
250 [make Medicaid inpatient hospital access payments to hospitals in accordance with this section,  
251 Section 26-36a-204, and Subsection 26-36a-203(7)], for accountable care organization rates  
252 effective on or after April 1, 2013, incorporate an amount equal to \$154 million into the  
253 accountable care organization rate structure consistent with the certified actuarial rate range.

254 [(2) (a) The Medicaid inpatient hospital access payment amount to a particular hospital  
255 shall be established by the division.]

256 [(b) The aggregate of all hospital's Medicaid inpatient hospital access payments shall  
257 be:]

258 [(i) equal to the upper payment limit gap for inpatient services for all hospitals; and]

259 [(ii) designated as the Medicaid inpatient hospital access payment pool.]

260 [(3) In addition to any other funds paid to hospitals during fiscal years 2010 and 2011  
261 for inpatient hospital services to Medicaid patients, a Medicaid hospital inpatient access  
262 payment shall be made:]

263 [(a) for state fiscal years 2010 and 2011:]

264 [(i) the amount of \$825 per Medicaid fee for service day, to a hospital that:]

265 [(A) was not a specialty hospital; and]

266 [(B) had less than 300 select access inpatient cases during state fiscal year 2008; and]

267 [(ii) inpatient hospital access payments as determined by dividing the remaining  
268 spending room available in the current year UPL, after offsetting the payments authorized  
269 under Subsection (3)(a)(i) by the total 2008 Medicaid inpatient hospital payments, multiplied  
270 by the hospital's Medicaid inpatient payments for state fiscal year 2008, exclusive of medical  
271 education and Medicaid disproportionate share payments;]

272 [(b) for state fiscal year 2012:]

273 [(i) the amount of \$825 per Medicaid fee for service day, to a hospital that:]

274 [(A) is not a specialty hospital; and]

275 [(B) has less than 300 select access inpatient cases during the state fiscal year 2008;

276 and]

277 ~~[(ii) inpatient hospital access payments as determined by dividing the remaining~~  
278 ~~spending room available in the current year upper payment limit, after offsetting the payments~~  
279 ~~authorized under Subsection (3)(a)(i), by the total 2009 Medicaid inpatient hospital payments;~~  
280 ~~multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2009; and]~~

281 ~~[(c) for state fiscal year 2013:]~~

282 ~~[(i) the amount of \$825 per Medicaid fee for service day, to a hospital that:]~~

283 ~~[(A) is not a specialty hospital; and]~~

284 ~~[(B) has less than 300 select access inpatient cases during the state fiscal year 2008;~~

285 and]

286 ~~[(ii) inpatient hospital access payments as determined by dividing the remaining~~  
287 ~~spending room available in the current year upper payment limit, after offsetting the payments~~  
288 ~~authorized under Subsection (3)(a)(i), by the total 2010 Medicaid inpatient hospital payments;~~  
289 ~~multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2010:]~~

290 ~~[(4) Medicaid inpatient hospital access payments shall be made:]~~

291 ~~[(a) on a quarterly basis for inpatient hospital services furnished to Medicaid~~  
292 ~~individuals during each quarter; and]~~

293 ~~[(b) within 15 days after the end of each quarter:]~~

294 ~~[(5) A hospital's Medicaid inpatient access payment shall not be used to offset any~~  
295 ~~other payment by Medicaid for hospital inpatient or outpatient services to Medicaid~~  
296 ~~beneficiaries, including a:]~~

297 ~~[(a) fee-for-service payment;]~~

298 ~~[(b) per diem payment;]~~

299 ~~[(c) hospital inpatient adjustment; or]~~

300 ~~[(d) cost settlement payment:]~~

301 ~~[(6) When the division obtains approval from the Centers for Medicare and Medicaid~~  
302 ~~Services for the Medicaid Waiver - Accountable Care Organizations, and has determined the~~  
303 ~~capitated rate for the accountable care organizations, the department shall consult with the Utah~~  
304 ~~Hospitals Association to develop an alternative supplemental payment methodology that can be~~  
305 ~~approved by the Centers for Medicare and Medicaid Services:]~~

306 ~~[(7) A hospital shall not be guaranteed that the hospital's Medicaid inpatient hospital~~

307 ~~access payments will equal or exceed the amount of the hospital's assessment.]~~

308 Section 6. Section **26-36a-206** is amended to read:

309 **26-36a-206. Penalties and interest.**

310 (1) A facility that fails to pay any assessment or file a return as required under this  
311 chapter, within the time required by this chapter, shall pay, in addition to the assessment,  
312 penalties and interest established by the department.

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

316 (b) If a hospital fails to timely pay the full amount of a quarterly assessment, the  
317 department shall add to the assessment:

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

319 and

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

322 (A) any unpaid quarterly assessment; and

323 (B) any unpaid penalty assessment.

324 ~~[(c) The division may waive, reduce, or compromise the penalties and interest provided  
325 for in this section in the same manner as provided in Subsection 59-1-401(8).]~~

326 (c) Upon making a record of its actions, and upon reasonable cause shown, the division  
327 may waive, reduce, or compromise any of the penalties imposed under this part.

328 Section 7. Section **26-36a-207** is amended to read:

329 **26-36a-207. Restricted Special Revenue Fund -- Creation -- Deposits.**

330 (1) There is created a restricted special revenue fund known as the "Hospital Provider  
331 Assessment Special Revenue Fund."

332 (2) The fund shall consist of:

333 (a) the assessments collected by the department under this chapter;

334 (b) any interest and penalties levied with the administration of this chapter; and

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

337 (3) Money in the fund shall be used:

338 ~~[(a) to make inpatient hospital access payments under Section 26-36a-205; and]~~  
339 (a) to support capitated rates for accountable care organizations in an amount equal to  
340 \$154 million; and

341 (b) to reimburse money collected by the division from a hospital through a mistake  
342 made under this chapter.

343 Section 8. Section **26-36a-208** is amended to read:

344 **26-36a-208. Repeal of assessment.**

345 (1) The repeal of the assessment imposed by this chapter shall occur upon the  
346 certification by the executive director of the department that the sooner of the following has  
347 occurred:

348 (a) the effective date of any action by Congress that would disqualify the assessment  
349 imposed by this chapter from counting towards state Medicaid funds available to be used to  
350 determine the federal financial participation;

351 (b) the effective date of any decision, enactment, or other determination by the  
352 Legislature or by any court, officer, department, or agency of the state, or of the federal  
353 government that has the effect of:

354 (i) disqualifying the assessment from counting towards state Medicaid funds available  
355 to be used to determine federal financial participation for Medicaid matching funds; or

356 (ii) creating for any reason a failure of the state to use the assessments for the Medicaid  
357 program as described in this chapter; ~~and]~~

358 (c) the effective date of:

359 (i) an appropriation for any state fiscal year from the General Fund for hospital  
360 payments under the state Medicaid program that is less than the amount appropriated for state  
361 fiscal year 2012;

362 (ii) the annual revenues of the state General Fund budget return to the level that was  
363 appropriated for fiscal year 2008;

364 (iii) approval of any change in the state Medicaid plan that requires a greater  
365 percentage of Medicaid patients to enroll in Medicaid managed care plans than what is  
366 required:

367 (A) to implement accountable care organizations in the state plan; and

368 (B) by other managed care enrollment requirements in effect on or before January 1,

369 2012;

370 (iv) a division change in rules that reduces any of the following below July 1, 2011

371 payments:

372 (A) aggregate hospital inpatient payments;

373 (B) adjustment payment rates; or

374 (C) any cost settlement protocol; or

375 (v) a division change in rules that reduces the aggregate outpatient payments below

376 July 1, 2011, payments[-]; and

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

378 (2) If the assessment is repealed under Subsection (1), money in the fund that was

379 derived from assessments imposed by this chapter, before the determination made under

380 Subsection (1), shall be disbursed under Section 26-36a-205 to the extent federal matching is

381 not reduced due to the impermissibility of the assessments. Any funds remaining in the special

382 revenue fund shall be refunded to the hospitals in proportion to the amount paid by each

383 hospital.

384 Section 9. Section **63I-1-226** is amended to read:

385 **63I-1-226. Repeal dates, Title 26.**

386 (1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July  
387 1, 2015.

388 (2) Section 26-18-12, Expansion of 340B drug pricing programs, is repealed July 1,  
389 2013.

390 (3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed  
391 July 1, 2016.

392 (4) Section 26-21-211 is repealed July 1, 2013.

393 (5) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2014.

394 (6) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, [~~2013~~]  
395 2016.

396 (7) Section 26-38-2.5 is repealed July 1, 2017.

397 (8) Section 26-38-2.6 is repealed July 1, 2017.

398 Section 10. **Repealer.**

399 This bill repeals:

400 Section **26-36a-209, State plan amendment.**

401 Section 11. **Effective date.**

402 If approved by two-thirds of all the members elected to each house, this bill takes effect

403 on April 1, 2013.

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**Legislative Review Note**  
as of **2-4-13 3:33 PM**

**Office of Legislative Research and General Counsel**