LEGISLATIVE GENERAL COUNSEL
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H.B. 437
3rd Sub. (Cherry)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH CARE REVISIONS

2016 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Allen M. Christensen

LONG TITLE

General Description:

This bill implements a health coverage improvement program through Medicaid waiver authority granted to states before the federal Patient Protection and Affordable Care Act, and establishes a funding mechanism for the waiver program.

Highlighted Provisions:

This bill:

- authorizes a preferred drug list for psychotropic drugs with an override for dispense as written;
- establishes targets for savings from the preferred drug list;
- authorizes the Department of Health to apply for waivers from federal law necessary to implement a health coverage improvement program in Medicaid;
- distinguishes the health coverage improvement program from Medicaid expansion under the Affordable Care Act;
- defines terms;
- describes the Medicaid waiver request;
- permits a waiver enrollee to maintain Medicaid coverage for 12 months;
- provides eligibility criteria;
- amends the county matching funds for enrollees in the health coverage improvement

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program;

- expands Medicaid eligibility for adults with dependent children;
- requires the Department of Health to apply for a waiver for the existing Medicaid population and the enrollees in the health coverage improvement program to allow substance abuse treatment at facilities with no bed capacity limits;
- enhances the efficiency of Medicaid enrollment for adults released from incarceration;
- establishes an inpatient private hospital assessment to fund the Medicaid waiver;
- establishes a mandatory intergovernmental transfer of funds from the state teaching hospital and certain other government owned hospitals to fund the Medicaid waiver;
- authorizes the Public Employees' Benefit and Insurance Program to provide services for drugs and devices for certain individuals at the request of a procurement unit; and
- requires the Department of Health to study methods to increase coverage to uninsured low income adults with children and to maximize the use of employer sponsored coverage.

Money Appropriated in this Bill:

This bill appropriates $2,508,500 ongoing General Fund from other programs to the Medicaid Expansion Fund and makes changes to other funds.

Other Special Clauses:

This bill provides a coordination clause.

Utah Code Sections Affected:

AMENDS:

26-18-2.4, as last amended by Laws of Utah 2012, Chapters 242 and 343

26-18-18, as last amended by Laws of Utah 2015, Chapter 283

49-20-401, as last amended by Laws of Utah 2015, Chapter 155

63I-1-226, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258

ENACTS:

26-18-411, Utah Code Annotated 1953

26-36b-101, Utah Code Annotated 1953

26-36b-102, Utah Code Annotated 1953

26-36b-103, Utah Code Annotated 1953
26-36b-201, Utah Code Annotated 1953
26-36b-202, Utah Code Annotated 1953
26-36b-203, Utah Code Annotated 1953
26-36b-204, Utah Code Annotated 1953
26-36b-205, Utah Code Annotated 1953
26-36b-206, Utah Code Annotated 1953
26-36b-207, Utah Code Annotated 1953
26-36b-208, Utah Code Annotated 1953
26-36b-209, Utah Code Annotated 1953
26-36b-210, Utah Code Annotated 1953
26-36b-211, Utah Code Annotated 1953

Utah Code Sections Affected by Coordination Clause:

26-18-2.4, as last amended by Laws of Utah 2012, Chapters 242 and 343

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

Section 1. Section **26-18-2.4** is amended to read:

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), on a preferred drug list:

(i) to the extent determined appropriate by the department; and

(ii) in the manner described in Subsection (3) for psychotropic drugs;

(d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and except as provided in Subsection (3), 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 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) 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) 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) 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 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-depressants, anti-convulsant/mood stabilizer, anti-anxiety, attention deficit hyperactivity disorder stimulants, or sedative/hypnotics.~~]

[~~(iii)~~] (ii) "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 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)(e), 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 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 health care provider meets the criteria of demonstrating to the Department of Health 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) The department shall grant a prior authorization for a sedative hypnotic that is not on the preferred drug list under Subsection (2)(e), if the health care provider has documentation related to 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) A prior authorization granted under Subsection (2)(f) is valid for one year from the date the department grants the prior authorization and shall be renewed in accordance with Subsection (2)(f).

(3) (a) For purposes of this Subsection (3), "psychotropic drug" means the following classes of drugs:

(i) atypical anti-psychotic;

(ii) anti-depressant;

(iii) anti-convulsant/mood stabilizer;

(iv) anti-anxiety; and

(v) attention deficit hyperactivity disorder stimulant.

(b) The department shall develop a preferred drug list for psychotropic drugs. Except as provided in Subsection (3)(d), a preferred drug list for psychotropic drugs developed under this section shall allow a health care provider to override the preferred drug list by writing "dispense as written" on the prescription for the psychotropic drug. A health care provider may not override Section 58-17b-606 by writing "dispense as written" on a prescription.

(c) The department, and a Medicaid accountable care organization that is responsible for providing behavioral health, shall:

(i) establish a system to:

(A) track health care provider prescribing patterns for psychotropic drugs;

(B) educate health care providers who are not complying with the preferred drug list; and

(C) implement peer to peer education for health care providers whose prescribing practices continue to not comply with the preferred drug list; and

(ii) determine whether health care provider compliance with the preferred drug list is at least:

(A) 55% of prescriptions by July 1, 2017;

(B) 65% of prescriptions by July 1, 2018; and

(C) 75% of prescriptions by July 1, 2019.

(d) Beginning October 1, 2019, the department shall eliminate the dispense as written override for the preferred drug list, and shall implement a prior authorization system for psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has not realized annual savings from implementing the preferred drug list for psychotropic drugs of at least $750,000 General Fund savings.

(e) The department shall report to the Health and Human Services Interim Committee

and the Social Services Appropriations Subcommittee before November 30, 2016, and before each November 30 thereafter regarding compliance with and savings from implementation of this Subsection (3).

[~~(3)~~] (4) The department shall report to the Health and Human Services Interim Committee and to the Social Services Appropriations Subcommittee [~~prior to~~] before November 1, 2013, regarding the savings to the Medicaid program resulting from the use of the preferred drug list permitted by Subsection (1).

Section 2. Section **26-18-18** is amended to read:

26-18-18. Optional Medicaid expansion.

(1) For purposes of this section [~~PPACA is as~~], "PPACA" means the same as that term is defined in Section 31A-1-301.

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

[~~(a) the Health Reform Task Force has completed a thorough analysis of a statewide charity care system;~~]

[~~(b) the department and its contractors have:~~]

[~~(i) completed a thorough analysis of the impact to the state of expanding the state's Medicaid program to optional populations under PPACA; and~~]

[~~(ii) made the analysis conducted under Subsection (2)(b)(i) available to the public;~~]

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

[~~(d)~~] (b) notwithstanding Subsection 63J-5-103(2), the governor submits the request for expansion of the Medicaid program for optional populations to the Legislature under the high impact federal funds request process required by Section 63J-5-204, Legislative review and approval of certain federal funds request.

(3) The department shall request approval from the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services for waivers from federal statutory and regulatory law necessary to implement the health coverage improvement program under Section 26-18-411. The health coverage improvement program under Section 26-18-411 is not Medicaid expansion for purposes of this section.

Section 3. Section **26-18-411** is enacted to read:

26-18-411. Health coverage improvement program -- Eligibility -- Annual report -- Expansion of eligibility for adults with dependent children.

(1) For purposes of this section:

(a) "Adult in the expansion population" means an individual who:

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

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

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

(c) "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. Sec. 9909(2).

(d) "Homeless":

(i) means an individual who is chronically homeless, as determined by the department; and

(ii) includes someone who was chronically homeless and is currently living in supported housing for the chronically homeless.

(e) "Income eligibility ceiling" means the percent of federal poverty level:

(i) established by the state in an appropriations act adopted pursuant to Title 63J, Chapter 1, Budgetary Procedures Act; and

(ii) under which an individual may qualify for Medicaid coverage in accordance with this section.

(2) (a) No later than July 1, 2016, the division shall submit to CMS a request for waivers, or an amendment of existing waivers, from federal statutory and regulatory law necessary for the state to implement the health coverage improvement program in the Medicaid program in accordance with this section.

(b) An adult in the expansion population is eligible for Medicaid if the adult meets the income eligibility and other criteria established under Subsection (3).

(c) An adult who qualifies under Subsection (3) shall receive Medicaid coverage:

(i) through:

(A) the traditional fee for service Medicaid model in counties without Medicaid

accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented; and

(B) except as provided in Subsection (2)(c)(ii), for behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;

(ii) that integrates behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that chose an integrated model; and

(iii) that permits temporary residential treatment for substance abuse in a short term, non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan;

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

(3) (a) An individual is eligible for the health coverage improvement program under Subsection (2)(b) if:

(i) at the time of enrollment, the individual's annual income is below the income eligibility ceiling established by the state under Subsection (1)(e); and

(ii) the individual meets the eligibility criteria established by the department under Subsection (3)(b).

(b) Based on available funding and approval from CMS, the department shall select the criteria for an individual to qualify for the Medicaid program under Subsection (3)(a)(ii), based on the following priority:

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

(A) involved in the justice system through probation, parole, or court ordered treatment; and

(B) in need of substance abuse treatment or mental health treatment, as determined by the department; or

(iii) if funding is available, an individual in need of substance abuse treatment or mental health treatment, as determined by the department.

(c) An individual who qualifies for Medicaid coverage under Subsections (3)(a) and (b) may remain on the Medicaid program for a 12-month certification period as defined by the department. Eligibility changes made by the department under Subsection (1)(e) or (3)(b) shall not apply to an individual during the 12-month certification period.

(4) The state may request a modification of the income eligibility ceiling and other eligibility criteria under Subsection (3) each fiscal year based on enrollment in the health coverage improvement program, projected enrollment, costs to the state, and the state budget.

(5) On or before September 30, 2017, and on or before September 30 each year thereafter, the department shall report to the Legislature's Health and Human Services Interim Committee and to the Legislature's Executive Appropriations Committee:

(a) the number of individuals who enrolled in Medicaid under Subsection (2);

(b) the state cost of providing Medicaid to individuals enrolled under Subsection (2); and

(c) recommendations for adjusting the income eligibility ceiling under Subsection (4), and other eligibility criteria under Subsection (3), for the upcoming fiscal year.

(6) In addition to the waiver under Subsection (2), beginning July 1, 2016, the department shall amend the state Medicaid plan:

(a) for an individual with a dependent child, to increase the income eligibility ceiling to a percent of the federal poverty level designated by the department, based on appropriations for the program; and

(b) to allow temporary residential treatment for substance abuse, for the traditional Medicaid population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan, as approved by CMS and as long as the county makes the required match under Section 17-43-201.

(7) The current Medicaid program and the health coverage improvement program, when implemented, shall coordinate with a state prison or county jail to expedite Medicaid enrollment for an individual who is released from custody and was eligible for or enrolled in Medicaid before incarceration.

(8) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to provide matching funds to the state for the cost of providing Medicaid services to newly

enrolled individuals who qualify for Medicaid coverage under the health coverage improvement program under Subsection (3).

(9) The department shall:

(a) study, in consultation with health care providers, employers, uninsured families, and community stakeholders:

(i) options to maximize use of employer sponsored coverage for current Medicaid enrollees; and

(ii) strategies to increase participation of currently Medicaid eligible, and uninsured, children; and

(b) report the findings of the study to the Legislature's Health Reform Task Force before November 30, 2016.

Section 4. Section **26-36b-101** is enacted to read:

CHAPTER 36b. INPATIENT HOSPITAL ASSESSMENT ACT

Part 1. General Provisions

26-36b-101. Title.

This chapter is known as "Inpatient Hospital Assessment Act."

Section 5. Section **26-36b-102** is enacted to read:

26-36b-102. Application.

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

(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 chapter may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

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

(a) license a hospital for revenue;

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

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

Section 6. Section **26-36b-103** is enacted to read:

26-36b-103. Definitions.

As used in this chapter:

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

(2) "CMS" means the same as that term is defined in Section 26-18-411.

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

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

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

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

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

(6) "Non-state government hospital":

(a) means a hospital owned by a non-state government entity; and

(b) does not include:

(i) the Utah State Hospital; or

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

(7) "Private hospital":

(a) means:

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

(ii) a privately owned 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 a residential care or treatment facility as defined in Section 62A-2-101.

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

Section 7. Section **26-36b-201** is enacted to read:

Part 2. Assessment and Collection

26-36b-201. Assessment.

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

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

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

(ii) the assessment under this chapter;

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

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

(2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26-36b-210 have been paid.

(3) The first quarterly payment shall not be due until at least three months after the effective date of the coverage provided through the health coverage improvement program waiver under Section 26-18-411.

Section 8. Section **26-36b-202** is enacted to read:

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

(1) The collecting agent for assessment imposed under Section 26-36b-201 is the department. The department is vested with the administration and enforcement of this chapter, 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 chapter;

(b) audit records of a facility that:

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

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

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

(2) The department shall:

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

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

Section 9. Section **26-36b-203** is enacted to read:

26-36b-203. 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. The department may, by rule, extend the time for paying the assessment.

Section 10. Section **26-36b-204** is enacted to read:

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) a $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.

Section 11. Section **26-36b-205** is enacted to read:

26-36b-205. Calculation of assessment.

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

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

(c) The uniform assessment rate shall be determined using the total number of hospital discharges for assessed private hospitals, the percentages in Subsection 26-36b-204(2), and rule adopted by the department.

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

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

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

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

(b) 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 the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (2)(c)(i); 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.

Section 12. Section **26-36b-206** is enacted to read:

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

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

(2) The intergovernmental transfer shall be paid beginning on the later of CMS approval of:

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

(b) the assessment for private hospitals in this chapter; and

(c) the intergovernmental transfer in this section.

(3) The intergovernmental transfer shall be paid in an amount divided as follows:

(a) the state teaching hospital is responsible for:

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

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

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

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

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

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate the method of calculating the percentages designated in Subsection (3) and the schedule for the intergovernmental transfers.

Section 13. Section **26-36b-207** is enacted to read:

26-36b-207. Penalties and interest.

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

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

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

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

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

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

(B) any unpaid penalty assessment.

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

Section 14. Section **26-36b-208** is enacted to read:

26-36b-208. Medicaid Expansion Fund.

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

(2) The fund consists of:

(a) assessments collected under this chapter;

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

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

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

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

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

(g) 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 the health coverage improvement Medicaid waiver under Section 26-18-411, and the outpatient UPL supplemental payments under Section 26-36b-210, not otherwise paid for with federal funds or other revenue sources, except that no funds described in Subsection (2)(b) may be used to pay the cost of outpatient UPL supplemental payments.

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

Section 15. Section **26-36b-209** is enacted to read:

26-36b-209. Hospital reimbursement.

The department shall, to the extent allowed by law, include in a contract with a Medicaid accountable care organization a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network, no less than the Medicaid fee-for-service rate. Nothing in this section prohibits a Medicaid accountable care organization from paying a rate that exceeds Medicaid fee-for-service rates.

Section 16. Section **26-36b-210** is enacted to read:

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

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

(2) Beginning on the effective date of the assessment imposed under this chapter, and for each fiscal year thereafter, the department shall implement an outpatient upper payment limit program for private hospitals that shall supplement the reimbursement to private hospitals in accordance with Subsection (3).

(3) The supplemental payment to Utah private hospitals under Subsection (2) shall:

(a) not exceed the positive UPL gap; and

(b) be allocated based on the Medicaid state plan.

(4) The outpatient data used to calculate the UPL gap under Subsection (1) shall be the same outpatient data used to allocate the payments under Subsection (3).

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

(a) July 1, 2016;

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

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

Section 17. Section **26-36b-211** is enacted to read:

26-36b-211. Repeal of assessment.

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

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

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

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

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

(c) the effective date of a change that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015; and

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

(2) If the assessment is repealed under Subsection (1), money in the fund that was derived from assessments imposed by this chapter, before the determination made under

Subsection (1), shall be disbursed under Section 26-36b-207 to the extent federal matching is not reduced due to the impermissibility of the assessments. Any funds remaining in the special revenue fund shall be refunded to the hospitals in proportion to the amount paid by each hospital.

Section 18. Section **49-20-401** is amended to read:

49-20-401. Program -- Powers and duties.

(1) The program shall:

(a) act as a self-insurer of employee benefit plans and administer those plans;

(b) enter into contracts with private insurers or carriers to underwrite employee benefit plans as considered appropriate by the program;

(c) indemnify employee benefit plans or purchase commercial reinsurance as considered appropriate by the program;

(d) provide descriptions of all employee benefit plans under this chapter in cooperation with covered employers;

(e) process claims for all employee benefit plans under this chapter or enter into contracts, after competitive bids are taken, with other benefit administrators to provide for the administration of the claims process;

(f) obtain an annual actuarial review of all health and dental benefit plans and a periodic review of all other employee benefit plans;

(g) consult with the covered employers to evaluate employee benefit plans and develop recommendations for benefit changes;

(h) annually submit a budget and audited financial statements to the governor and Legislature which includes total projected benefit costs and administrative costs;

(i) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the employee benefit plans as certified by the program's consulting actuary;

(j) submit, in advance, its recommended benefit adjustments for state employees to:

(i) the Legislature; and

(ii) the executive director of the state Department of Human Resource Management;

(k) determine benefits and rates, upon approval of the board, for multiemployer risk pools, retiree coverage, and conversion coverage;

(l) determine benefits and rates based on the total estimated costs and the employee

premium share established by the Legislature, upon approval of the board, for state employees;

(m) administer benefits and rates, upon ratification of the board, for single employer risk pools;

(n) request proposals for provider networks or health and dental benefit plans administered by third party carriers at least once every three years for the purposes of:

(i) stimulating competition for the benefit of covered individuals;

(ii) establishing better geographical distribution of medical care services; and

(iii) providing coverage for both active and retired covered individuals;

(o) offer proposals which meet the criteria specified in a request for proposals and accepted by the program to active and retired state covered individuals and which may be offered to active and retired covered individuals of other covered employers at the option of the covered employer;

(p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for the Department of Health if the program provides program benefits to children enrolled in the Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act;

(q) establish rules and procedures governing the admission of political subdivisions or educational institutions and their employees to the program;

(r) contract directly with medical providers to provide services for covered individuals;

(s) take additional actions necessary or appropriate to carry out the purposes of this chapter; [~~and~~]

(t) (i) require state employees and their dependents to participate in the electronic exchange of clinical health records in accordance with Section 26-1-37 unless the enrollee opts out of participation; and

(ii) prior to enrolling the state employee, each time the state employee logs onto the program's website, and each time the enrollee receives written enrollment information from the program, provide notice to the enrollee of the enrollee's participation in the electronic exchange of clinical health records and the option to opt out of participation at any time[~~.~~]; and

(u) provide services for drugs or medical devices at the request of a procurement unit, as that term is defined in Section 63G-6a-104, that administers benefits to program recipients who are not covered by Title 26, Utah Health Code.

(2) (a) Funds budgeted and expended shall accrue from rates paid by the covered employers and covered individuals.

(b) Administrative costs shall be approved by the board and reported to the governor and the Legislature.

(3) The Department of Human Resource Management shall include the benefit adjustments described in Subsection (1)(j) in the total compensation plan recommended to the governor required under Subsection 67-19-12(5)(a).

Section 19. Section **63I-1-226** is amended to read:

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

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

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

(3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed July 1, 2018.

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

(5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2016.

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

[~~(6)~~] (7) Section 26-38-2.5 is repealed July 1, 2017.

[~~(7)~~] (8) Section 26-38-2.6 is repealed July 1, 2017.

[~~(8)~~] (9) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.

Section 20. **Appropriation.**

Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for the fiscal year beginning July 1, 2016, and ending June 30, 2017, the following sums of money are appropriated from resources not otherwise appropriated, or reduced from amounts previously appropriated, out of the funds or amounts indicated. These sums of money are in addition to amounts previously appropriated for fiscal year 2017.

To Fund and Account Transfers -- State Endowment Fund

From General Fund Restricted -- Tobacco Settlement Account ($1,488,700)

Schedule of Programs:

State Endowment Fund ($1,488,700)

To Department of Health -- Medicaid Optional Services

From General Fund ($1,488,700)

From General Fund Restricted -- Tobacco Settlement Account $1,488,700

To Department of Human Services -- Substance Abuse and Mental Health

From General Fund ($819,800)

From General Fund, one-time $ Ĥ→ **[~~498,000~~] 419,800** ←Ĥ

From Federal Funds $819,800

From Federal Funds, one-time Ĥ→ **[~~($498,000)~~] ($419,800)** ←Ĥ

To Department of Human Services -- Child and Family Services

From General Fund ($200,000)

Schedule of Programs:

Out-of-home Care ($200,000)

To Department of Health -- Medicaid Expansion Fund

From General Fund $2,508,500

From General Fund, one-time Ĥ→ **[~~($498,000)~~] ($419,800)** ←Ĥ

Schedule of Programs:

Medicaid Expansion Fund Ĥ→ **[~~$2,010,500~~] $2,088,700** ←Ĥ

Section 21. **Coordinating H.B. 437 with H.B. 18 -- Superseding amendment.**

If this H.B. 437 and H.B. 18, Medicaid Preferred Drug List Amendments, both pass and become law, it is the intent of the Legislature that the amendments to Section 26-18-2.4 in this bill supersede the amendments to Section 26-18-2.4 in H.B. 18, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.