

**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

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**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



26 program;

- 27 ▶ expands Medicaid eligibility for adults with dependent children;
- 28 ▶ requires the Department of Health to apply for a waiver for the existing Medicaid

29 population and the enrollees in the health coverage improvement program to allow

30 substance abuse treatment at facilities with no bed capacity limits;

- 31 ▶ enhances the efficiency of Medicaid enrollment for adults released from
- 32 incarceration;

- 33 ▶ establishes an inpatient private hospital assessment to fund the Medicaid waiver;

- 34 ▶ establishes a mandatory intergovernmental transfer of funds from the state teaching
- 35 hospital and certain other government owned hospitals to fund the Medicaid waiver;

- 36 ▶ authorizes the Public Employees' Benefit and Insurance Program to provide services
- 37 for drugs and devices for certain individuals at the request of a procurement unit;

38 and

- 39 ▶ requires the Department of Health to study methods to increase coverage to
- 40 uninsured low income adults with children and to maximize the use of employer
- 41 sponsored coverage.

42 **Money Appropriated in this Bill:**

43 This bill appropriates \$2,508,500 ongoing General Fund from other programs to the

44 Medicaid Expansion Fund and makes changes to other funds.

45 **Other Special Clauses:**

46 This bill provides a coordination clause.

47 **Utah Code Sections Affected:**

48 AMENDS:

49 **26-18-2.4**, as last amended by Laws of Utah 2012, Chapters 242 and 343

50 **26-18-18**, as last amended by Laws of Utah 2015, Chapter 283

51 **49-20-401**, as last amended by Laws of Utah 2015, Chapter 155

52 **63I-1-226**, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258

53 ENACTS:

54 **26-18-411**, Utah Code Annotated 1953

55 **26-36b-101**, Utah Code Annotated 1953

56 **26-36b-102**, Utah Code Annotated 1953

- 57 [26-36b-103](#), Utah Code Annotated 1953
- 58 [26-36b-201](#), Utah Code Annotated 1953
- 59 [26-36b-202](#), Utah Code Annotated 1953
- 60 [26-36b-203](#), Utah Code Annotated 1953
- 61 [26-36b-204](#), Utah Code Annotated 1953
- 62 [26-36b-205](#), Utah Code Annotated 1953
- 63 [26-36b-206](#), Utah Code Annotated 1953
- 64 [26-36b-207](#), Utah Code Annotated 1953
- 65 [26-36b-208](#), Utah Code Annotated 1953
- 66 [26-36b-209](#), Utah Code Annotated 1953
- 67 [26-36b-210](#), Utah Code Annotated 1953
- 68 [26-36b-211](#), Utah Code Annotated 1953

69 **Utah Code Sections Affected by Coordination Clause:**

70 [26-18-2.4](#), as last amended by Laws of Utah 2012, Chapters 242 and 343



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

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

74 **26-18-2.4. Medicaid drug program -- Preferred drug list.**

75 (1) A Medicaid drug program developed by the department under Subsection

76 [26-18-2.3\(2\)\(f\)](#):

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

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

82 (c) may include placing some drugs, except the drugs described in Subsection (2), on a  
83 preferred drug list:

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

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

86 (d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and  
87 except as provided in Subsection (3), shall immediately implement the prior authorization

88 requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:

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

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

91 (e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior  
92 authorization requirements established under Subsections (1)(c) and (d) which shall permit a  
93 health care provider or the health care provider's agent to obtain a prior authorization override  
94 of the preferred drug list through the department's pharmacy prior authorization review process,  
95 and which shall:

96 (i) provide either telephone or fax approval or denial of the request within 24 hours of  
97 the receipt of a request that is submitted during normal business hours of Monday through  
98 Friday from 8 a.m. to 5 p.m.;

99 (ii) provide for the dispensing of a limited supply of a requested drug as determined  
100 appropriate by the department in an emergency situation, if the request for an override is  
101 received outside of the department's normal business hours; and

102 (iii) require the health care provider to provide the department with documentation of  
103 the medical need for the preferred drug list override in accordance with criteria established by  
104 the department in consultation with the Pharmacy and Therapeutics Committee.

105 (2) (a) For purposes of this Subsection (2):

106 (i) "Immunosuppressive drug":

107 (A) means a drug that is used in immunosuppressive therapy to inhibit or prevent  
108 activity of the immune system to aid the body in preventing the rejection of transplanted organs  
109 and tissue; and

110 (B) does not include drugs used for the treatment of autoimmune disease or diseases  
111 that are most likely of autoimmune origin.

112 [~~(ii) "Psychotropic drug" means the following classes of drugs: atypical anti-psychotic,  
113 anti-depressants, anti-convulsant/mood stabilizer, anti-anxiety, attention deficit hyperactivity  
114 disorder stimulants, or sedative/hypnotics.]~~

115 [(~~iii~~) (ii) "Stabilized" means a health care provider has documented in the patient's  
116 medical chart that a patient has achieved a stable or steadfast medical state within the past 90  
117 days using a particular psychotropic drug.

118 (b) A preferred drug list developed under the provisions of this section may not

119 include[: (i) ~~except as provided in Subsection (2)(e), a psychotropic or anti-psychotic drug; or~~  
120 ~~(ii)] an immunosuppressive drug.~~

121 (c) The state Medicaid program shall reimburse for a prescription for an  
122 immunosuppressive drug as written by the health care provider for a patient who has undergone  
123 an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to patients  
124 who have undergone an organ transplant, the prescription for a particular immunosuppressive  
125 drug as written by a health care provider meets the criteria of demonstrating to the Department  
126 of Health a medical necessity for dispensing the prescribed immunosuppressive drug.

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

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

132 (f) The department shall grant a prior authorization for a sedative hypnotic that is not  
133 on the preferred drug list under Subsection (2)(e), if the health care provider has documentation  
134 related to one of the following conditions for the Medicaid client:

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

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

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

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

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

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

147 (g) A prior authorization granted under Subsection (2)(f) is valid for one year from the  
148 date the department grants the prior authorization and shall be renewed in accordance with  
149 Subsection (2)(f).

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

- 152 (i) atypical anti-psychotic;
- 153 (ii) anti-depressant;
- 154 (iii) anti-convulsant/mood stabilizer;
- 155 (iv) anti-anxiety; and
- 156 (v) attention deficit hyperactivity disorder stimulant.

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

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

- 164 (i) establish a system to:
  - 165 (A) track health care provider prescribing patterns for psychotropic drugs;
  - 166 (B) educate health care providers who are not complying with the preferred drug list;

167 and

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

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

- 172 (A) 55% of prescriptions by July 1, 2017;
- 173 (B) 65% of prescriptions by July 1, 2018; and
- 174 (C) 75% of prescriptions by July 1, 2019.

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

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

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

184 ~~[(3)]~~ (4) The department shall report to the Health and Human Services Interim  
185 Committee and to the Social Services Appropriations Subcommittee ~~[prior to]~~ before  
186 November 1, 2013, regarding the savings to the Medicaid program resulting from the use of the  
187 preferred drug list permitted by Subsection (1).

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

189 **26-18-18. Optional Medicaid expansion.**

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

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

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

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

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

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

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

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

207 (3) The department shall request approval from the Centers for Medicare and Medicaid  
208 Services within the United States Department of Health and Human Services for waivers from  
209 federal statutory and regulatory law necessary to implement the health coverage improvement  
210 program under Section 26-18-411. The health coverage improvement program under Section  
211 26-18-411 is not Medicaid expansion for purposes of this section.

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

213 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**

214 **-- Expansion of eligibility for adults with dependent children.**

215 (1) For purposes of this section:

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

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

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

219 individual.

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

222 (c) "Federal poverty level" means the poverty guidelines established by the secretary of  
223 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).

224 (d) "Homeless":

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

226 and

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

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

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

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

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

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

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

241 (i) through:

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



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

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

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

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

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

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

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

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

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

266 (i) a chronically homeless individual;

267 (ii) if funding is available, an individual:

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

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

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

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

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

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

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

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

286 and

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

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

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

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

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

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

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

307 (9) The department shall:

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

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

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

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

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

317 **CHAPTER 36b. INPATIENT HOSPITAL ASSESSMENT ACT**

318 **Part 1. General Provisions**

319 **26-36b-101. Title.**

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

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

322 **26-36b-102. Application.**

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

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

327 (b) other applicable federal law;

328 (c) any state law;

329 (d) any ad valorem property taxes;

330 (e) any sales or use taxes; or

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

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

- 336 (3) This chapter does not authorize a political subdivision of the state to:
- 337 (a) license a hospital for revenue;
- 338 (b) impose a tax or assessment upon a hospital; or
- 339 (c) impose a tax or assessment measured by the income or earnings of a hospital.

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

341 **26-36b-103. Definitions.**

342 As used in this chapter:

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

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

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

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

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

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

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

353 (6) "Non-state government hospital":

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

355 (b) does not include:

356 (i) the Utah State Hospital; or

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

359 (7) "Private hospital":

360 (a) means:

361 (i) a privately owned general acute hospital operating in the state as defined in Section

362 [26-21-2](#); and

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

365 (A) rehabilitation;

366 (B) psychiatric;

- 367 (C) chemical dependency; or
- 368 (D) long-term acute care services; and
- 369 (b) does not include a residential care or treatment facility as defined in Section
- 370 62A-2-101.

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

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

**Part 2. Assessment and Collection**

**26-36b-201. Assessment.**

- 376 (1) An assessment is imposed on each private hospital:
- 377 (a) beginning upon the later of CMS approval of:
- 378 (i) the health coverage improvement program waiver under Section 26-18-411; and
- 379 (ii) the assessment under this chapter;
- 380 (b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and
- 381 (c) in accordance with Section 26-36b-202.
- 382 (2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and  
 383 payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental  
 384 payments under Section 26-36b-210 have been paid.
- 385 (3) The first quarterly payment shall not be due until at least three months after the  
 386 effective date of the coverage provided through the health coverage improvement program  
 387 waiver under Section 26-18-411.

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

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

- 390 (1) The collecting agent for assessment imposed under Section 26-36b-201 is the  
 391 department. The department is vested with the administration and enforcement of this chapter,  
 392 including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah  
 393 Administrative Rulemaking Act, necessary to:
- 394 (a) implement and enforce the provisions of this chapter;
- 395 (b) audit records of a facility that:
- 396 (i) is subject to the assessment imposed by this chapter; and
- 397 (ii) does not file a Medicare cost report; and

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

400 (2) The department shall:

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

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

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

406 **26-36b-203. Quarterly notice.**

407 Quarterly assessments imposed by this chapter shall be paid to the division within 15  
408 business days after the original invoice date that appears on the invoice issued by the division.

409 The department may, by rule, extend the time for paying the assessment.

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

411 **26-36b-204. Hospital financing of health coverage improvement program**

412 **Medicaid waiver -- Hospital share.**

413 (1) For purposes of this section, "hospital share":

414 (a) means 45% of the state's net cost of:

415 (i) the health coverage improvement program Medicaid waiver under Section  
416 26-18-411;

417 (ii) Medicaid coverage for individuals with dependent children up to the federal  
418 poverty level designated under Section 26-18-411; and

419 (iii) the UPL gap, as that term is defined in Section 26-36b-210;

420 (b) for the hospital share of the additional coverage under Section 26-18-411, is capped  
421 at no more than \$13,600,000 annually, consisting of:

422 (i) a \$11,900,000 cap on the hospital's share for the programs specified in Subsections  
423 (1)(a)(i) and (ii); and

424 (ii) a \$1,700,000 cap for the program specified in Subsection (1)(a)(iii);

425 (c) for the cap specified in Subsection (1)(b), shall be prorated in any year in which the  
426 programs specified in Subsection (1)(a) are not in effect for the full fiscal year; and

427 (d) if the Medicaid program expands in a manner that is greater than the expansion  
428 described in Section 26-18-411, is capped at 33% of the state's share of the cost of the

429 expansion that is in addition to the program described in Section 26-18-411.

430 (2) The assessment for the private hospital share under Subsection (1) shall be:

431 (a) 69% of the portion of the hospital share specified in Subsections (1)(a)(i) and (ii);

432 and

433 (b) 100% of the portion of the hospital share specified in Subsection (1)(a)(iii).

434 (3) (a) The department shall, on or before October 15, 2017, and on or before October  
435 15 of each year thereafter, produce a report that calculates the state's net cost of the programs  
436 described in Subsections (1)(a)(i) and (ii).

437 (b) If the assessment collected in the previous fiscal year is above or below the private  
438 hospital's share of the state's net cost as specified in Subsection (2), for the previous fiscal year,  
439 the underpayment or overpayment of the assessment by the private hospitals shall be applied to  
440 the fiscal year in which the report was issued.

441 (4) A Medicaid accountable care organization shall, on or before October 15 of each  
442 year, report to the department the following data from the prior state fiscal year:

443 (a) for the traditional Medicaid population, for each private hospital, state teaching  
444 hospital, and non-state government hospital provider:

445 (i) hospital inpatient payments;

446 (ii) hospital inpatient discharges;

447 (iii) hospital inpatient days; and

448 (iv) hospital outpatient payments; and

449 (b) for the Medicaid population newly eligible under Subsection 26-18-411, for each  
450 private hospital, state teaching hospital, and non-state government hospital provider:

451 (i) hospital inpatient payments;

452 (ii) hospital inpatient discharges;

453 (iii) hospital inpatient days; and

454 (iv) hospital outpatient payments.

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

456 **26-36b-205. Calculation of assessment.**

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

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

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

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

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

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

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

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

477 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report  
478 applicable to the assessment year; and

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

480 (c) If a hospital is not certified by the Medicare program and is not required to file a  
481 Medicare cost report:

482 (i) the hospital shall submit to the division the hospital's applicable fiscal year  
483 discharges with supporting documentation;

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

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

488 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that  
489 owns more than one hospital in the state:

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



491 and

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

493 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the  
494 same Medicaid provider number:

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

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

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

499 **26-36b-206. State teaching hospital and non-state government hospital mandatory**  
500 **intergovernmental transfer.**

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

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

506 (a) the health improvement program waiver under Section [26-18-411](#);

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

508 (c) the intergovernmental transfer in this section.

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

510 (a) the state teaching hospital is responsible for:

511 (i) 30% of the portion of the hospital share specified in Subsections  
512 [26-36b-204\(1\)\(a\)\(i\)](#) and (ii); and

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

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

515 (i) 1% of the portion of the hospital share specified in Subsections [26-36b-204\(1\)\(a\)\(i\)](#)  
516 and (ii); and

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

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

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

522 **26-36b-207. Penalties and interest.**

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

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

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

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

534 and

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

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

538 (B) any unpaid penalty assessment.

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

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

543 **26-36b-208. Medicaid Expansion Fund.**

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

546 (2) The fund consists of:

547 (a) assessments collected under this chapter;

548 (b) intergovernmental transfers under Section [26-36b-206](#);

549 (c) savings attributable to the health coverage improvement program under Section  
550 [26-18-411](#) as determined by the department;

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

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

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

557 (g) additional amounts as appropriated by the Legislature.

558 (3) (a) The fund shall earn interest.

559 (b) All interest earned on fund money shall be deposited into the fund.

560 (4) (a) A state agency administering the provisions of this chapter may use money from  
561 the fund to pay the costs of the health coverage improvement Medicaid waiver under Section  
562 26-18-411, and the outpatient UPL supplemental payments under Section 26-36b-210, not  
563 otherwise paid for with federal funds or other revenue sources, except that no funds described  
564 in Subsection (2)(b) may be used to pay the cost of outpatient UPL supplemental payments.

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

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

567 **26-36b-209. Hospital reimbursement.**

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

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

574 **26-36b-210. Outpatient upper payment limit supplemental payments.**

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

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

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

583 (a) not exceed the positive UPL gap; and

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

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

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

589 (a) July 1, 2016;

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

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

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

595 **26-36b-211. Repeal of assessment.**

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

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

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

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

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

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

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

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

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

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

620 **49-20-401. Program -- Powers and duties.**

621 (1) The program shall:

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

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

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

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

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

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

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

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

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

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

641 (i) the Legislature; and

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

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

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

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

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

648 risk pools;

649 (n) request proposals for provider networks or health and dental benefit plans

650 administered by third party carriers at least once every three years for the purposes of:

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

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

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

654 (o) offer proposals which meet the criteria specified in a request for proposals and

655 accepted by the program to active and retired state covered individuals and which may be

656 offered to active and retired covered individuals of other covered employers at the option of the

657 covered employer;

658 (p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for

659 the Department of Health if the program provides program benefits to children enrolled in the

660 Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's

661 Health Insurance Act;

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

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

665 (s) take additional actions necessary or appropriate to carry out the purposes of this

666 chapter; ~~and~~

667 (t) (i) require state employees and their dependents to participate in the electronic

668 exchange of clinical health records in accordance with Section [26-1-37](#) unless the enrollee opts

669 out of participation; and

670 (ii) prior to enrolling the state employee, each time the state employee logs onto the

671 program's website, and each time the enrollee receives written enrollment information from the

672 program, provide notice to the enrollee of the enrollee's participation in the electronic exchange

673 of clinical health records and the option to opt out of participation at any time[-]; and

674 (u) provide services for drugs or medical devices at the request of a procurement unit,

675 as that term is defined in Section [63G-6a-104](#), that administers benefits to program recipients

676 who are not covered by Title 26, Utah Health Code.

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

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

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

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

685 **63I-1-226. Repeal dates, Title 26.**

686 (1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July  
687 1, 2025.

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

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

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

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

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

694 [~~(6)~~] (7) Section 26-38-2.5 is repealed July 1, 2017.

695 [~~(7)~~] (8) Section 26-38-2.6 is repealed July 1, 2017.

696 [~~(8)~~] (9) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.

697 **Section 20. Appropriation.**

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

703 To Fund and Account Transfers -- State Endowment Fund

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

705 Schedule of Programs:

706 State Endowment Fund (\$1,488,700)

707 To Department of Health -- Medicaid Optional Services

708	<u>From General Fund</u>	<u>(\$1,488,700)</u>
709	<u>From General Fund Restricted -- Tobacco Settlement Account</u>	<u>\$1,488,700</u>
710	<u>To Department of Human Services -- Substance Abuse and Mental Health</u>	
711	<u>From General Fund</u>	<u>(\$819,800)</u>
712	<u>From General Fund, one-time</u>	<u>\$498,000</u>
713	<u>From Federal Funds</u>	<u>\$819,800</u>
714	<u>From Federal Funds, one-time</u>	<u>(\$498,000)</u>
715	<u>To Department of Human Services -- Child and Family Services</u>	
716	<u>From General Fund</u>	<u>(\$200,000)</u>
717	<u>Schedule of Programs:</u>	
718	<u>Out-of-home Care</u>	<u>(\$200,000)</u>
719	<u>To Department of Health -- Medicaid Expansion Fund</u>	
720	<u>From General Fund</u>	<u>\$2,508,500</u>
721	<u>From General Fund, one-time</u>	<u>(\$498,000)</u>
722	<u>Schedule of Programs:</u>	
723	<u>Medicaid Expansion Fund</u>	<u>\$2,010,500</u>

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

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