

Representative Steve Eliason proposes the following substitute bill:

PRIMARY CARE NETWORK AMENDMENTS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Steve Eliason

Senate Sponsor: Brian Zehnder

LONG TITLE

General Description:

This bill creates a new waiver program to provide enhanced benefits for certain individuals in the Medicaid program, and provides funding for the enhancement waiver program through an existing hospital assessment and a portion of the growth in alcohol and tobacco tax revenues.

Highlighted Provisions:

This bill:

- directs the Department of Health to apply for a new waiver or an amendment to an existing waiver to implement the Primary Care Network enhancement waiver program described in this bill; ~~and~~

- amends the Inpatient Hospital Assessment Act to pay for the cost of the enhancement waiver program ~~and~~

~~[dedicates a portion of the growth in the state's revenue from alcohol and tobacco taxes to pay for the cost of the enhancement waiver program.]~~

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

4th Sub. H.B. 325



26 This bill provides coordination clauses.

27 **Utah Code Sections Affected:**

28 AMENDS:

29 26-18-411, as enacted by Laws of Utah 2016, Chapter 279

30 26-36b-102, as enacted by Laws of Utah 2016, Chapter 279

31 26-36b-103, as enacted by Laws of Utah 2016, Chapter 279

32 26-36b-201, as enacted by Laws of Utah 2016, Chapter 279

33 26-36b-202, as enacted by Laws of Utah 2016, Chapter 279

34 26-36b-203, as enacted by Laws of Utah 2016, Chapter 279

35 26-36b-204, as enacted by Laws of Utah 2016, Chapter 279

36 26-36b-205, as enacted by Laws of Utah 2016, Chapter 279

37 26-36b-206, as enacted by Laws of Utah 2016, Chapter 279

38 26-36b-207, as enacted by Laws of Utah 2016, Chapter 279

39 26-36b-208, as enacted by Laws of Utah 2016, Chapter 279

40 26-36b-209, as enacted by Laws of Utah 2016, Chapter 279

41 26-36b-210, as enacted by Laws of Utah 2016, Chapter 279

42 26-36b-211, as enacted by Laws of Utah 2016, Chapter 279

43 ~~§→ [32B-2-301, as last amended by Laws of Utah 2017, Chapter 159~~

44 ~~— 59-14-204, as last amended by Laws of Utah 2016, Chapter 168] ←§~~

45 63I-1-226, as last amended by Laws of Utah 2017, Chapters 177 and 443

46 ENACTS:

47 26-18-415, Utah Code Annotated 1953

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

49 26-18-415, Utah Code Annotated 1953

50 26-36b-103, as enacted by Laws of Utah 2016, Chapter 279

51 26-36b-201, as enacted by Laws of Utah 2016, Chapter 279

52 26-36b-204, as enacted by Laws of Utah 2016, Chapter 279

53 26-36b-206, as enacted by Laws of Utah 2016, Chapter 279

54 26-36b-208, as enacted by Laws of Utah 2016, Chapter 279

55 26-36b-209, as enacted by Laws of Utah 2016, Chapter 279

56 26-36b-211, as enacted by Laws of Utah 2016, Chapter 279

57

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

59 Section 1. Section **26-18-411** is amended to read:

60 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
61 **-- Expansion of eligibility for adults with dependent children.**

62 (1) For purposes of this section:

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

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

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

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

69 (c) "Enhancement waiver program" means the Primary Care Network enhancement
70 waiver program described in Section 26-18-415.

71 ~~(d)~~ (d) "Federal poverty level" means the poverty guidelines established by the
72 Secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec.
73 9909(2).

74 (e) "Health coverage improvement program" means the health coverage improvement
75 program described in Subsections (3) through (10).

76 ~~(f)~~ (f) "Homeless":

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

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

81 ~~(g)~~ (g) "Income eligibility ceiling" means the percent of federal poverty level:

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

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

86 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
87 allow temporary residential treatment for substance abuse, for the traditional Medicaid

88 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that
89 provides rehabilitation services that are medically necessary and in accordance with an
90 individualized treatment plan, as approved by CMS and as long as the county makes the
91 required match under Section 17-43-201.

92 (3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
93 increase the income eligibility ceiling to a percentage of the federal poverty level designated by
94 the department, based on appropriations for the program, for an individual with a dependent
95 child.

96 ~~[(2)(a) No later than]~~

97 (4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an
98 amendment of existing waivers, from federal statutory and regulatory law necessary for the
99 state to implement the health coverage improvement program in the Medicaid program in
100 accordance with this section.

101 ~~[(b)]~~ (5) (a) An adult in the expansion population is eligible for Medicaid if the adult
102 meets the income eligibility and other criteria established under Subsection ~~[(3)]~~ (6).

103 ~~[(c)]~~ (b) An adult who qualifies under Subsection ~~[(3)]~~ (6) shall receive Medicaid
104 coverage:

105 (i) through~~[(A)]~~ the traditional fee for service Medicaid model in counties without
106 Medicaid accountable care organizations or the state's Medicaid accountable care organization
107 delivery system, where implemented; ~~[and]~~

108 ~~[(B)]~~ (ii) except as provided in Subsection ~~[(2)(c)(ii)]~~ (5)(b)(iii), for behavioral health,
109 through the counties in accordance with Sections 17-43-201 and 17-43-301;

110 ~~[(ii)]~~ (iii) that integrates behavioral health services and physical health services with
111 Medicaid accountable care organizations in select geographic areas of the state that choose an
112 integrated model; and

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

117 ~~[(d)]~~ (c) Medicaid accountable care organizations and counties that elect to integrate
118 care under Subsection ~~[(2)(c)(ii)]~~ (5)(b)(iii) shall collaborate on enrollment, engagement of

119 patients, and coordination of services.

120 ~~[(3)]~~ (6) (a) An individual is eligible for the health coverage improvement program
121 under Subsection ~~[(2)(b)]~~ (5) if:

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

124 (ii) the individual meets the eligibility criteria established by the department under
125 Subsection ~~[(3)]~~ (6)(b).

126 (b) Based on available funding and approval from CMS, the department shall select the
127 criteria for an individual to qualify for the Medicaid program under Subsection ~~[(3)]~~ (6)(a)(ii),
128 based on the following priority:

129 (i) a chronically homeless individual;

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

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

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

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

137 (c) An individual who qualifies for Medicaid coverage under Subsections ~~[(3)]~~ (6)(a)
138 and (b) may remain on the Medicaid program for a 12-month certification period as defined by
139 the department. Eligibility changes made by the department under Subsection (1)~~[(e)]~~(g) or
140 ~~[(3)]~~ (6)(b) shall not apply to an individual during the 12-month certification period.

141 ~~[(4)]~~ (7) The state may request a modification of the income eligibility ceiling and
142 other eligibility criteria under Subsection ~~[(3)]~~ (6) each fiscal year based on enrollment in the
143 health coverage improvement program, projected enrollment, costs to the state, and the state
144 budget.

145 ~~[(5) On or before September 30, 2017, and on or before]~~

146 (8) Before September 30 of each year ~~[thereafter]~~, the department shall report to the
147 ~~[Legislature's]~~ Health and Human Services Interim Committee and to the ~~[Legislature's]~~
148 Executive Appropriations Committee:

149 (a) the number of individuals who enrolled in Medicaid under Subsection ~~[(3)]~~ (6);

150 (b) the state cost of providing Medicaid to individuals enrolled under Subsection [(3)]
151 (6); and

152 (c) recommendations for adjusting the income eligibility ceiling under Subsection [(4)]
153 (7), and other eligibility criteria under Subsection [(3)] (6), for the upcoming fiscal year.

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

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

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

164 [(7)] (9) The current Medicaid program and the health coverage improvement program,
165 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
166 enrollment for an individual who is released from custody and was eligible for or enrolled in
167 Medicaid before incarceration.

168 [(8)] (10) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have
169 to provide matching funds to the state for the cost of providing Medicaid services to newly
170 enrolled individuals who qualify for Medicaid coverage under the health coverage
171 improvement program under Subsection [(3)] (6).

172 [(9) The department shall:]

173 [~~(a) study, in consultation with health care providers, employers, uninsured families,~~
174 ~~and community stakeholders:]~~

175 [~~(i) options to maximize use of employer sponsored coverage for current Medicaid~~
176 ~~enrollees; and]~~

177 [~~(ii) strategies to increase participation of currently Medicaid eligible, and uninsured,~~
178 ~~children; and]~~

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

- 181 (11) If the enhancement waiver program is implemented, the department:
182 (a) may not accept any new enrollees into the health coverage improvement program
183 after the day on which the enhancement waiver program is implemented;
184 (b) shall transition all individuals who are enrolled in the health coverage improvement
185 program into the enhancement waiver program;
186 (c) shall suspend the health coverage improvement program within one year after the
187 day on which the enhancement waiver program is implemented;
188 (d) shall, within one year after the day on which the enhancement waiver program is
189 implemented, use all appropriations for the health coverage improvement program to
190 implement the enhancement waiver program; and
191 (e) shall work with CMS to maintain any waiver for the health coverage improvement
192 program while the health coverage improvement program is suspended under Subsection
193 (11)(c).
- 194 (12) If, after the enhancement waiver program takes effect, the enhancement waiver
195 program is repealed or suspended by either the state or federal government, the department
196 shall reinstate the health coverage improvement program and continue to accept new enrollees
197 into the health coverage improvement program in accordance with the provisions of this
198 section.
- 199 Section 2. Section **26-18-415** is enacted to read:
200 **26-18-415. Primary Care Network enhancement waiver program.**
- 201 (1) As used in this section:
202 (a) "CMS" means the Centers for Medicare and Medicaid Services within the United
203 States Department of Health and Human Services.
204 (b) "Enhancement waiver program" means the Primary Care Network enhancement
205 waiver program described in this section.
206 (c) "Federal poverty level" means the poverty guidelines established by the secretary of
207 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9902(2).
208 (d) "Health coverage improvement program" means the same as that term is defined in
209 Section [26-18-411](#).
210 (e) "Income eligibility ceiling" means the percentage of federal poverty level:
211 (i) established by the Legislature in an appropriations act adopted pursuant to Title 63J,

212 Chapter 1, Budgetary Procedures Act; and

213 (ii) under which an individual may qualify for coverage in the enhancement waiver
214 program in accordance with this section.

215 (f) "Optional population" means the optional expansion population under PPACA if
216 the expansion provides coverage for individuals at or above 95% of the federal poverty level.

217 (g) "PPACA" means the same as that term is defined in Section [31A-1-301](#).

218 (h) "Primary Care Network" means the state Primary Care Network program created by
219 the Medicaid primary care network demonstration waiver obtained under Section [26-18-3](#).

220 (2) The department shall continue to implement the Primary Care Network program for
221 qualified individuals under the Primary Care Network program.

222 (3) Before July 1, 2018, the division shall apply for a Medicaid waiver or a state plan
223 amendment with CMS to implement, within the state Medicaid program, the enhancement
224 waiver program described in this section.

225 (4) An individual who is eligible for the enhancement waiver program may receive the
226 following benefits under the enhancement waiver program:

227 (a) the benefits offered under the Primary Care Network program;

228 (b) diagnostic testing and procedures;

229 (c) medical specialty care;

230 (d) inpatient hospital services;

231 (e) outpatient hospital services;

232 (f) outpatient behavioral health care, including outpatient substance abuse care; and

233 (g) for an individual who qualifies for the health coverage improvement program, as
234 approved by CMS, temporary residential treatment for substance abuse in a short term,
235 non-institutional, 24-hour facility, without a bed capacity limit, that provides rehabilitation
236 services that are medically necessary and in accordance with an individualized treatment plan.

237 (5) An individual is eligible for the enhancement waiver program if, at the time of
238 enrollment:

239 (a) the individual is qualified to enroll in the Primary Care Network or the health
240 coverage improvement program;

241 (b) the individual's annual income is below the income eligibility ceiling established by
242 the Legislature under Subsection (1)(e); and

243 (c) the individual meets the eligibility criteria established by the department under
244 Subsection (6).

245 (6) (a) Based on available funding and approval from CMS and subject to Subsection
246 (6)(d), the department shall determine the criteria for an individual to qualify for the
247 enhancement waiver program, based on the following priority:

248 (i) adults in the expansion population, as defined in Section 26-18-411, who qualify for
249 the health coverage improvement program;

250 (ii) adults with dependent children who qualify for the health coverage improvement
251 program under Subsection 26-18-411(3);

252 (iii) adults with dependent children who do not qualify for the health coverage
253 improvement program; and

254 (iv) if funding is available, adults without dependent children.

255 (b) The number of individuals enrolled in the enhancement waiver program may not
256 exceed 105% of the number of individuals who were enrolled in the Primary Care Network on
257 December 31, 2017.

258 (c) The department may only use appropriations from the Medicaid Expansion Fund
259 created in Section 26-36b-208 to fund the state portion of the enhancement waiver program.

260 (d) The money deposited into the Medicaid Expansion Fund under Subsections
261 26-36b-208(g) and (h) may only be used to pay the cost of enrolling individuals who qualify for
262 the enhancement waiver program under Subsections (6)(a)(iii) and (iv).

263 (7) The department may request a modification of the income eligibility ceiling and the
264 eligibility criteria under Subsection (6) from CMS each fiscal year based on enrollment in the
265 enhancement waiver program, projected enrollment in the enhancement waiver program, costs
266 to the state, and the state budget.

267 (8) The department may implement the enhancement waiver program by contracting
268 with Medicaid accountable care organizations to administer the enhancement waiver program.

269 (9) In accordance with Subsections 26-18-411(11) and (12), the department may use
270 funds that have been appropriated for the health coverage improvement program to implement
271 the enhancement waiver program.

272 (10) If the department expands the state Medicaid program to the optional population,
273 the department:

274 (a) except as provided in Subsection (11), may not accept any new enrollees into the
275 enhancement waiver program after the day on which the expansion to the optional population
276 is effective;

277 (b) shall suspend the enhancement waiver program within one year after the day on
278 which the expansion to the optional population is effective; and

279 (c) shall work with CMS to maintain the waiver for the enhancement waiver program
280 submitted under Subsection (3) while the enhancement waiver program is suspended under
281 Subsection (10)(b).

282 (11) If, after the expansion to the optional population described in Subsection (10)
283 takes effect, the expansion to the optional population is repealed by either the state or the
284 federal government, the department shall reinstate the enhancement waiver program and
285 continue to accept new enrollees into the enhancement waiver program in accordance with the
286 provisions of this section.

287 Section 3. Section **26-36b-102** is amended to read:

288 **26-36b-102. Application.**

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

292 [~~(a) Section 501(c), as amended, of the Internal Revenue Code;~~]

293 [~~(b) other applicable federal law;~~]

294 [~~(c)~~] (a) [any] state law;

295 [~~(d)~~] (b) [any] ad valorem property taxes;

296 [~~(e)~~] (c) [any] sales or use taxes; or

297 [~~(f)~~] (d) [any] other taxes, fees, or assessments, whether imposed or sought to be
298 imposed, by the state or any political subdivision [~~county, municipality, district, authority, or~~
299 ~~any agency or department thereof~~] of the state.

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

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

303 (a) license a hospital for revenue;

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

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

306 Section 4. Section **26-36b-103** is amended to read:

307 **26-36b-103. Definitions.**

308 As used in this chapter:

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

310 (2) "CMS" means the ~~[same as that term is defined in Section 26-18-411]~~ Centers for
311 Medicare and Medicaid Services within the United States Department of Health and Human
312 Services.

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

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

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

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

319 (5) "Enhancement waiver program" means the program established by the Primary
320 Care Network enhancement waiver program described in Section 26-18-415.

321 (6) "Health coverage improvement program" means the health coverage improvement
322 program described in Section 26-18-411.

323 (7) "Hospital share" means the hospital share described in Section 26-36b-203.

324 (8) "Medicaid accountable care organization" means a managed care organization, as
325 defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of
326 Section 26-18-405.

327 ~~[(5)]~~ (9) "Medicare cost report" means CMS-2552-10, the cost report for electronic
328 filing of hospitals.

329 ~~[(6)]~~ (10) (a) "Non-state government hospital"~~[(a)]~~ means a hospital owned by a
330 non-state government entity~~[(a)]~~.

331 (b) "Non-state government hospital" does not include:

332 (i) the Utah State Hospital; or

333 (ii) a hospital owned by the federal government, including the Veterans Administration
334 Hospital.

335 ~~[(7)]~~ (11) (a) "Private hospital"~~[(a)]~~ means:

336 (i) a [~~privately owned~~] general acute hospital [~~operating in the state~~], as defined in
337 Section 26-21-2, that is privately owned and operating in the state; and

338 (ii) a privately owned specialty hospital operating in the state, [~~which shall include~~]
339 including a privately owned hospital whose inpatient admissions are predominantly for:

340 (A) rehabilitation;

341 (B) psychiatric care;

342 (C) chemical dependency services; or

343 (D) long-term acute care services[~~and~~].

344 (b) "Private hospital" does not include a facility for residential [~~care or~~] treatment
345 [~~facility~~] as defined in Section 62A-2-101.

346 [(8)] (12) "State teaching hospital" means a state owned teaching hospital that is part of
347 an institution of higher education.

348 (13) "Upper payment limit gap" means the difference between the private hospital
349 outpatient upper payment limit and the private hospital Medicaid outpatient payments, as
350 determined in accordance with 42 C.F.R. Sec. 447.321.

351 Section 5. Section **26-36b-201** is amended to read:

352 **26-36b-201. Assessment.**

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

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

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

356 (ii) the assessment under this chapter;

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

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

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

362 (3) The first quarterly payment [~~shall not be~~] is not due until at least three months after
363 the earlier of the effective [date] dates of the coverage provided through:

364 (a) the health coverage improvement program [~~waiver under Section 26-18-411~~]; or

365 (b) the enhancement waiver program.

366 Section 6. Section **26-36b-202** is amended to read:

367 **26-36b-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**368 (1) The collecting agent for the assessment imposed under Section [26-36b-201](#) is the
369 department.370 (2) The department is vested with the administration and enforcement of this chapter,
371 [~~including the right to adopt administrative~~] and may make rules in accordance with Title 63G,
372 Chapter 3, Utah Administrative Rulemaking Act, necessary to:373 [~~(a) implement and enforce the provisions of this chapter;~~]374 (a) collect the assessment, intergovernmental transfers, and penalties imposed under
375 this chapter;

376 (b) audit records of a facility that:

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

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

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

381 (2) The department shall:

382 (a) administer the assessment in this [~~part separate~~] chapter separately from the
383 assessment in Chapter 36a, Hospital Provider Assessment Act; and384 (b) deposit assessments collected under this chapter into the Medicaid Expansion Fund
385 created by Section [26-36b-208](#).386 Section 7. Section **26-36b-203** is amended to read:387 **26-36b-203. Quarterly notice.**388 (1) Quarterly assessments imposed by this chapter shall be paid to the division within
389 15 business days after the original invoice date that appears on the invoice issued by the
390 division.

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

392 Section 8. Section **26-36b-204** is amended to read:393 **26-36b-204. Hospital financing of health coverage improvement program**
394 **Medicaid waiver -- Hospital share.**395 [~~(1) For purposes of this section, "hospital share":(a) means~~]396 (1) The hospital share is:397 (a) 45% of the state's net cost of [~~-(i)] the health coverage improvement program~~

398 [~~Medicaid waiver under Section 26-18-411; (ii)~~], including Medicaid coverage for individuals
 399 with dependent children up to the federal poverty level designated under Section 26-18-411;

400 [~~and~~]

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

402 (b) 45% of the state's net cost of the enhancement waiver program; and

403 (c) 45% of the state's net cost of the upper payment limit gap.

404 [~~(b) for the hospital share of the additional coverage under Section 26-18-411;~~]

405 (2) (a) The hospital share is capped at no more than \$13,600,000 annually, consisting

406 of:

407 (i) an \$11,900,000 cap [~~on the hospital's share~~] for the programs specified in

408 Subsections (1)(a)[~~(i) and (ii)~~] and (b); and

409 (ii) a \$1,700,000 cap for the program specified in Subsection [~~(1)(a)(iii);~~] (1)(c).

410 [~~(c) for the cap specified in Subsection (1)(b), shall be prorated]~~

411 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in

412 which the programs specified in ~~§~~ → **[Subsection] Subsections** ← ~~§~~ (1)(a) and (c) are not in effect
 412a for the full fiscal

413 year[~~; and~~].

414 [~~(d)~~] (c) [if] If the Medicaid program expands in a manner that is greater than the

415 expansion described in Section 26-18-411[~~;~~] and the enhancement described in Section

416 26-18-415, the hospital share is capped at 33% of the state's share of the cost of the expansion

417 or enhancement that is in addition to the [program] programs described in Section 26-18-411 or

418 26-18-415.

419 [~~(2) The assessment for the private hospital share under Subsection (1) shall be:~~]

420 (3) Private hospitals shall be assessed under this chapter for:

421 (a) 69% of the portion of the hospital share specified in Subsections (1)(a)[~~(i) and (ii)~~]

422 and (b); and

423 (b) 100% of the portion of the hospital share specified in Subsection (1)[~~(a)(iii)~~](c).

424 [~~(3)~~] (4) (a) The department shall, on or before October 15, 2017, and on or before

425 October 15 of each subsequent year [~~thereafter~~], produce a report that calculates the state's net

426 cost of the programs described in Subsections (1)(a)[~~(i) and (ii)~~] and (b) that are in effect for

427 that year.

428 (b) If the assessment collected in the previous fiscal year is above or below the [private

429 ~~hospital's share of the state's net cost as specified in Subsection (2);]~~ hospital share for private
 430 hospitals for the previous fiscal year, the underpayment or overpayment of the assessment by
 431 the private hospitals shall be applied to the fiscal year in which the report [~~was~~] is issued.

432 [~~(4)~~] (5) A Medicaid accountable care organization shall, on or before October 15 of
 433 each year, report to the department the following data from the prior state fiscal year for each
 434 private hospital, state teaching hospital, and non-state government hospital provider that the
 435 Medicaid accountable care organization contracts with:

436 (a) for the traditional Medicaid population [~~, for each private hospital, state teaching~~
 437 ~~hospital, and non-state government hospital provider]:~~

438 (i) hospital inpatient payments;

439 (ii) hospital inpatient discharges;

440 (iii) hospital inpatient days; and

441 (iv) hospital outpatient payments; and

442 [~~(b) for the Medicaid population newly eligible under Subsection 26-18-411, for each~~
 443 ~~private hospital, state teaching hospital, and non-state government hospital provider:]~~

444 (b) if the Medicaid accountable care organization enrolls any individuals in the health
 445 coverage improvement program or the enhancement waiver program, for the population newly
 446 eligible for either program:

447 (i) hospital inpatient payments;

448 (ii) hospital inpatient discharges;

449 (iii) hospital inpatient days; and

450 (iv) hospital outpatient payments.

451 (6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
 452 Administrative Rulemaking Act, provide details surrounding specific content and format for
 453 the reporting by the Medicaid accountable care organization.

454 Section 9. Section **26-36b-205** is amended to read:

455 **26-36b-205. Calculation of assessment.**

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

459 (b) A private teaching hospital with more than 425 beds and 60 residents shall pay an

460 assessment rate ~~[2.50]~~ 2.5 times the uniform rate established under Subsection (1)(c).

461 (c) The division shall calculate the uniform assessment rate ~~[shall be determined using~~
462 ~~the total number of hospital discharges for assessed private hospitals, the percentages in~~
463 ~~Subsection 26-36b-204(2), and rule adopted by the department.]~~ described in Subsection (1)(a)
464 by dividing the hospital share for assessed private hospitals, described in Subsection
465 26-36b-204(1), by the sum of:

466 (i) the total number of discharges for assessed private hospitals that are not a private
467 teaching hospital; and

468 (ii) 2.5 times the number of discharges for a private teaching hospital, described in
469 Subsection (1)(b).

470 (d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah
471 Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address
472 unforeseen circumstances in the administration of the assessment under this chapter.

473 ~~[(d)]~~ (e) Any quarterly changes to the uniform assessment rate shall be applied
474 uniformly to all assessed private hospitals.

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

479 (2) Except as provided in Subsection (3), for each state fiscal year, the division shall
480 determine a hospital's discharges as follows:

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

483 ~~[(ii)]~~ (b) for each subsequent state fiscal year, the hospital's cost report data for the
484 hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal
485 year.

486 ~~[(b)]~~ (3) (a) If a hospital's fiscal year Medicare cost report is not contained in the
487 ~~[Centers for Medicare and Medicaid Services']~~ CMS Healthcare Cost Report Information
488 System file:

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

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

492 ~~[(e)]~~ (b) If a hospital is not certified by the Medicare program and is not required to file
493 a Medicare cost report:

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

496 (ii) the division shall determine the hospital's discharges from the information
497 submitted under Subsection ~~[(2)(e)(i)]~~ (3)(b)(i); and

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

500 ~~[(3)]~~ (4) Except as provided in Subsection ~~[(4)]~~ (5), if a hospital is owned by an
501 organization that owns more than one hospital in the state:

502 (a) the assessment for each hospital shall be separately calculated by the department;
503 and

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

505 ~~[(4) Notwithstanding the requirement of Subsection (3), if]~~

506 (5) If multiple hospitals use the same Medicaid provider number:

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

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

510 Section 10. Section **26-36b-206** is amended to read:

511 **26-36b-206. State teaching hospital and non-state government hospital**
512 **mandatory intergovernmental transfer.**

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

516 (2) The ~~[intergovernmental transfer shall be paid]~~ hospitals described in Subsection (1)
517 shall pay the intergovernmental transfer beginning on the later of CMS approval of:

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

519 (b) the assessment for private hospitals in this chapter~~[-and]~~.

520 ~~[(c) the intergovernmental transfer in this section.]~~

521 (3) The intergovernmental transfer ~~[shall be paid in an amount divided]~~ is apportioned

522 as follows:

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

524 (i) 30% of the portion of the hospital share specified in Subsections

525 ~~26-36b-204(1)(a)(i) and (ii)~~ and (b); and

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

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

528 (i) 1% of the portion of the hospital share specified in Subsections ~~26-36b-204(1)(a)(i)~~

529 ~~and (ii)~~ and (b); and

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

531 (4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah

532 Administrative Rulemaking Act, designate:

533 (a) the method of calculating the ~~[percentages]~~ amounts designated in Subsection (3);

534 and

535 (b) the schedule for the intergovernmental transfers.

536 Section 11. Section ~~26-36b-207~~ is amended to read:

537 **26-36b-207. Penalties.**

538 (1) A hospital that fails to pay ~~[any]~~ a quarterly assessment, make the mandated

539 intergovernmental transfer, or file a return as required under this chapter, within the time

540 required by this chapter, shall pay penalties described in this section, in addition to the

541 assessment or intergovernmental transfer~~[- and interest established by the department].~~

542 ~~[(2)(a) Consistent with Subsection (2)(b), the department shall adopt rules in~~

543 ~~accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish~~

544 ~~reasonable penalties and interest for the violations described in Subsection (1).]~~

545 ~~[(b)]~~ (2) If a hospital fails to timely pay the full amount of a quarterly assessment or the

546 mandated intergovernmental transfer, the department shall add to the assessment or

547 intergovernmental transfer:

548 ~~[(i)]~~ (a) a penalty equal to 5% of the quarterly amount not paid on or before the due

549 date; and

550 ~~[(ii)]~~ (b) on the last day of each quarter after the due date until the assessed amount and

551 the penalty imposed under Subsection (2)~~[(b)(i)]~~(a) are paid in full, an additional 5% penalty

552 on:

553 ~~[(A)]~~ (i) any unpaid quarterly assessment or intergovernmental transfer; and

554 ~~[(B)]~~ (ii) any unpaid penalty assessment.

555 ~~[(c)]~~ (3) Upon making a record of the division's actions, and upon reasonable cause
556 shown, the division may waive, reduce, or compromise any of the penalties imposed under this
557 chapter.

558 Section 12. Section **26-36b-208** is amended to read:

559 **26-36b-208. Medicaid Expansion Fund.**

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

562 (2) The fund consists of:

563 (a) assessments collected under this chapter;

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

565 (c) savings attributable to the health coverage improvement program ~~[under Section~~
566 [26-18-411](#)] as determined by the department;

567 (d) savings attributable to the enhancement waiver program as determined by the
568 department;

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

571 ~~[(e)]~~ (f) savings attributable to the services provided by the Public Employees' Health
572 Plan under Subsection [49-20-401\(1\)\(u\)](#);

573 ~~[(g)]~~ ~~the amount transferred under Subsection [32B-2-301\(7\)](#);~~

574 ~~[(h)]~~ ~~the amount transferred under Subsection [59-14-204\(6\)](#);~~ ~~←~~ ~~→~~

575 ~~[(f)]~~ ~~→~~ ~~(g)~~ ~~←~~ gifts, grants, donations, or any other conveyance of money that may be
575a made to

576 the fund from private sources; ~~[and]~~

577 ~~→~~ ~~(h)~~ ~~←~~ interest earned on money in the fund; and

578 ~~(g)~~ ~~→~~ ~~(h)~~ ~~(i)~~ ~~←~~ additional amounts as appropriated by the Legislature.

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

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

581 (4) (a) A state agency administering the provisions of this chapter may use money from
582 the fund to pay the costs ~~[of]~~, not otherwise paid for with federal funds or other revenue
583 sources, of:

584 (i) the health coverage improvement [~~Medicaid waiver under Section 26-18-411, and~~
585 program;

586 (ii) the enhancement waiver program; and

587 (iii) the outpatient [~~UPL~~] upper payment limit supplemental payments under Section
588 26-36b-210 [~~, not otherwise paid for with federal funds or other revenue sources, except that~~
589 ~~no~~].

590 (b) A state agency administering the provisions of this chapter may not use:

591 (i) funds described in Subsection (2)(b) [~~may be used~~] to pay the cost of private
592 outpatient [~~UPL~~] upper payment limit supplemental payments[~~;~~]; or

593 [~~(b)~~] (ii) [~~Money~~] money in the fund [~~may not be used~~] for any [~~other~~] purpose not
594 described in Subsection (4)(a).

595 Section 13. Section **26-36b-209** is amended to read:

596 **26-36b-209. Hospital reimbursement.**

597 (1) [~~The~~] If the health coverage improvement program or the enhancement waiver
598 program is implemented by contracting with a Medicaid accountable care organization, the
599 department shall, to the extent allowed by law, include, in a contract [~~with a Medicaid~~
600 accountable care organization] to provide benefits under the health coverage improvement
601 program or the enhancement waiver program, a requirement that the Medicaid accountable care
602 organization reimburse hospitals in the accountable care organization's provider network[~~;~~] at
603 no less than the Medicaid fee-for-service rate.

604 (2) If the health coverage improvement program or the enhancement waiver program is
605 implemented by the department as a fee-for-service program, the department shall reimburse
606 hospitals at no less than the Medicaid fee-for-service rate.

607 (3) Nothing in this section prohibits a Medicaid accountable care organization from
608 paying a rate that exceeds the Medicaid fee-for-service [~~rates~~] rate.

609 Section 14. Section **26-36b-210** is amended to read:

610 **26-36b-210. Outpatient upper payment limit supplemental payments.**

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

614 [~~(2)~~] (1) Beginning on the effective date of the assessment imposed under this chapter,

615 and for each subsequent fiscal year [~~thereafter~~], the department shall implement an outpatient
 616 upper payment limit program for private hospitals that shall supplement the reimbursement to
 617 private hospitals in accordance with Subsection [~~(3)~~] (2).

618 [~~(3)~~] (2) The division shall ensure that supplemental payment to Utah private hospitals
 619 under Subsection [~~(2)~~ shall] (1):

620 (a) does not exceed the positive [UPL] upper payment limit gap; and

621 (b) [~~be~~] is allocated based on the Medicaid state plan.

622 [~~(4)~~] (3) The department shall use the same outpatient data [~~used to calculate the UPL~~
 623 ~~gap under Subsection (1) shall be the same outpatient data used]~~ to allocate the payments under
 624 Subsection [~~(3)~~] (2) and to calculate the upper payment limit gap.

625 [~~(5)~~] (4) The supplemental payments to private hospitals under Subsection [~~(2)~~ shall
 626 ~~be~~] (1) are payable for outpatient hospital services provided on or after the later of:

627 (a) July 1, 2016;

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

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

632 Section 15. Section **26-36b-211** is amended to read:

633 **26-36b-211. Repeal of assessment.**

634 (1) The [~~repeal of the~~] assessment imposed by this chapter shall [~~occur upon the~~
 635 ~~certification by the executive director of the department that the sooner of the following has~~
 636 ~~occurred]~~ be repealed when:

637 [~~(a) the effective date of any]~~

638 (a) the executive director certifies that:

639 (i) action by Congress [~~that would disqualify~~] is in effect that disqualifies the
 640 assessment imposed by this chapter from counting toward state Medicaid funds available to be
 641 used to determine the amount of federal financial participation;

642 [~~(b) the effective date of any]~~

643 (ii) a decision, enactment, or other determination by the Legislature or by any court,
 644 officer, department, or agency of the state, or of the federal government, [~~that has the effect of~~]
 645 is in effect that:

646 ~~[(i) disqualifying]~~ (A) disqualifies the assessment from counting toward state
 647 Medicaid funds available to be used to determine federal financial participation for Medicaid
 648 matching funds; or

649 ~~[(ii) creating]~~ (B) creates for any reason a failure of the state to use the assessments for
 650 at least one of the Medicaid [program as] programs described in this chapter; or

651 ~~[(c) the effective date of]~~

652 (iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient
 653 payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1,
 654 2015; ~~[and] or~~

655 ~~[(d) the sunset of]~~ (b) this chapter is repealed in accordance with Section ~~631-1-226~~.

656 ~~[(2) If the assessment is repealed under Subsection (1), money in the fund that was~~
 657 ~~derived from assessments imposed by this chapter, before the determination made under~~
 658 ~~Subsection (1), shall be disbursed under Section 26-36b-207 to the extent federal matching is~~
 659 ~~not reduced due to the impermissibility of the assessments. Any funds remaining in the special~~
 660 ~~revenue fund shall be refunded to the hospitals in proportion to the amount paid by each~~
 661 ~~hospital.]~~

662 (2) If the assessment is repealed under Subsection (1):

663 (a) the division may not collect any assessment or intergovernmental transfer under this
 664 chapter;

665 (b) the department shall disburse money in the special Medicaid Expansion Fund in
 666 accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching
 667 is not reduced by CMS due to the repeal of the assessment;

668 (c) any money remaining in the Medicaid Expansion Fund after the disbursement
 669 described in Subsection (2)(b) that was derived from assessments imposed by this chapter shall
 670 be refunded to the hospitals in proportion to the amount paid by each hospital for the last three
 671 fiscal years; and

672 (d) any money remaining in the Medicaid Expansion Fund after the disbursements
 673 described in ~~§~~ → [Subsection] Subsections ← ~~§~~ (2)(b) and (c) shall be deposited into the General
 673a Fund by the end of
 674 the fiscal year that the assessment is suspended.

675 ~~§~~ → [Section 16. Section 32B-2-301 is amended to read:

676 ~~———— 32B-2-301. State property -- Liquor Control Fund -- Markup Holding Fund.☺~~

- 677 ~~☉~~ (1) The following are property of the state:
- 678 ~~_____ (a) the money received in the administration of this title, except as otherwise provided;~~
- 679 ~~and~~
- 680 ~~_____ (b) property acquired, administered, possessed, or received by the department.~~
- 681 ~~_____ (2) (a) There is created an enterprise fund known as the "Liquor Control Fund."~~
- 682 ~~_____ (b) Except as provided in Sections 32B-3-205 and 32B-2-304, money received in the~~
- 683 ~~administration of this title shall be transferred to the Liquor Control Fund.~~
- 684 ~~_____ (3) (a) There is created an enterprise fund known as the "Markup Holding Fund."~~
- 685 ~~_____ (b) In accordance with Section 32B-2-304, the State Tax Commission shall deposit~~
- 686 ~~revenue remitted to the State Tax Commission from the markup imposed under Section~~
- 687 ~~32B-2-304 into the Markup Holding Fund.~~
- 688 ~~_____ (c) Money deposited into the Markup Holding Fund may be expended:~~
- 689 ~~_____ (i) to the extent appropriated by the Legislature; and~~
- 690 ~~_____ (ii) to fund the deposits required by Subsection 32B-2-304(4) and Subsection~~
- 691 ~~32B-2-305(4).~~
- 692 ~~_____ (4) The department may draw from the Liquor Control Fund only to the extent~~
- 693 ~~appropriated by the Legislature or provided for by statute, except that the department may draw~~
- 694 ~~by warrant without an appropriation from the Liquor Control Fund for an expenditure that is~~
- 695 ~~directly incurred by the department:~~
- 696 ~~_____ (a) to purchase an alcoholic product;~~
- 697 ~~_____ (b) to transport an alcoholic product from the supplier to a warehouse of the~~
- 698 ~~department; and~~
- 699 ~~_____ (c) for variances related to an alcoholic product.~~
- 700 ~~_____ (5) (a) As used in this Subsection (5), "base budget" means the same as that term is~~
- 701 ~~defined in legislative rule.~~
- 702 ~~_____ (b) The department's base budget shall include as an appropriation from the Liquor~~
- 703 ~~Control Fund:~~
- 704 ~~_____ (i) credit card related fees paid by the department;~~
- 705 ~~_____ (ii) package agency compensation; and~~
- 706 ~~_____ (iii) the department's costs of shipping and warehousing alcoholic products.~~
- 707 ~~_____ (6) Before the transfer required by Subsection (7), the department may retain each~~ ☉

708 ~~☉fiscal year from the Liquor Control Fund \$1,000,000 that the department may use for:~~
 709 ~~—— (a) capital equipment purchases;~~
 710 ~~—— (b) salary increases for department employees;~~
 711 ~~—— (c) performance awards for department employees; or~~
 712 ~~—— (d) information technology enhancements because of changes or trends in technology.~~
 713 ~~—— (7) [The] (a) Except as provided in Subsection (7)(b), the department shall transfer~~
 714 ~~annually from the Liquor Control Fund and the State Tax Commission shall transfer annually~~
 715 ~~from the Markup Holding Fund to the General Fund a sum equal to the amount of net profit~~
 716 ~~earned from the sale of liquor since the preceding transfer of money under this Subsection (7).~~
 717 ~~The transfers shall be calculated by no later than September 1 and made by no later than~~
 718 ~~September 30 after a fiscal year. The Division of Finance may make year-end closing entries in~~
 719 ~~the Liquor Control Fund and the Markup Holding Fund in order to comply with Subsection~~
 720 ~~51-5-6(2).~~
 721 ~~—— (b) Subject to Subsection (7)(c), and in accordance with Subsection 26-36b-208(2)(f),~~
 722 ~~for each fiscal year beginning in fiscal year 2019, the department and the Division of Finance~~
 723 ~~shall transfer to the Medicaid Expansion Fund, created in Section 26-36b-208, any amount~~
 724 ~~described in Subsection (7)(a) in excess of the amount transferred by the department or the~~
 725 ~~Division of Finance in fiscal year 2018.~~
 726 ~~—— (c) The annual transfer to the Medicaid Expansion Fund, described in Subsection~~
 727 ~~(7)(b), shall be capped at:~~
 728 ~~—— (i) for fiscal year 2019, \$1,150,000; and~~
 729 ~~—— (ii) for a fiscal year beginning after fiscal year 2019, \$2,400,000.~~
 730 ~~—— (8) (a) By the end of each day, the department shall:~~
 731 ~~—— (i) make a deposit to a qualified depository, as defined in Section 51-7-3; and~~
 732 ~~—— (ii) report the deposit to the state treasurer.~~
 733 ~~—— (b) A commissioner or department employee is not personally liable for a loss caused~~
 734 ~~by the default or failure of a qualified depository.~~
 735 ~~—— (c) Money deposited in a qualified depository is entitled to the same priority of~~
 736 ~~payment as other public funds of the state.~~
 737 ~~—— (9) If the cash balance of the Liquor Control Fund is not adequate to cover a warrant~~
 738 ~~drawn against the Liquor Control Fund by the department, the cash resources of the General ☉~~

739 ~~☉Fund may be used to the extent necessary. At no time may the fund equity of the Liquor~~
740 ~~Control Fund fall below zero.~~

741 ~~———— Section 17. Section 59-14-204 is amended to read:~~
742 ~~———— 59-14-204. Tax basis -- Rate -- Future increase -- Cigarette Tax Restricted~~
743 ~~Account -- Appropriation and expenditure of revenues.~~

744 ~~———— (1) Except for cigarettes described under Subsection 59-14-210(3), there is levied a tax~~
745 ~~upon the sale, use, storage, or distribution of cigarettes in the state.~~

746 ~~———— (2) The rates of the tax levied under Subsection (1) are, beginning on July 1, 2010:~~
747 ~~———— (a) 8.5 cents on each cigarette, for all cigarettes weighing not more than three pounds~~
748 ~~per thousand cigarettes; and~~

749 ~~———— (b) 9.963 cents on each cigarette, for all cigarettes weighing in excess of three pounds~~
750 ~~per thousand cigarettes.~~

751 ~~———— (3) Except as otherwise provided under this chapter, the tax levied under Subsection~~
752 ~~(1) shall be paid by any person who is the manufacturer, jobber, importer, distributor,~~
753 ~~wholesaler, retailer, user, or consumer.~~

754 ~~———— (4) The tax rates specified in this section shall be increased by the commission by the~~
755 ~~same amount as any future reduction in the federal excise tax on cigarettes.~~

756 ~~———— (5) (a) There is created within the General Fund a restricted account known as the~~
757 ~~"Cigarette Tax Restricted Account."~~

758 ~~———— (b) The Cigarette Tax Restricted Account consists of:~~
759 ~~———— (i) the first \$7,950,000 of the revenues collected from a tax under this section; and~~
760 ~~———— (ii) any other appropriations the Legislature makes to the Cigarette Tax Restricted~~
761 ~~Account.~~

762 ~~———— (c) For each fiscal year beginning with fiscal year 2011-12 and subject to appropriation~~
763 ~~by the Legislature, the Division of Finance shall distribute money from the Cigarette Tax~~
764 ~~Restricted Account as follows:~~

765 ~~———— (i) \$250,000 to the Department of Health to be expended for a tobacco prevention and~~
766 ~~control media campaign targeted towards children;~~

767 ~~———— (ii) \$2,900,000 to the Department of Health to be expended for tobacco prevention,~~
768 ~~reduction, cessation, and control programs;~~

769 ~~———— (iii) \$2,000,000 to the University of Utah Health Sciences Center for the Huntsman☉~~

770 ~~☉Cancer Institute to be expended for cancer research; and~~

771 ~~—— (iv) \$2,800,000 to the University of Utah Health Sciences Center to be expended for~~
 772 ~~medical education at the University of Utah School of Medicine.~~

773 ~~—— (d) In determining how to appropriate revenue deposited into the Cigarette Tax~~
 774 ~~Restricted Account that is not otherwise appropriated under Subsection (5)(c), the Legislature~~
 775 ~~shall give particular consideration to enhancing Medicaid provider reimbursement rates and~~
 776 ~~medical coverage for the uninsured.~~

777 ~~—— (f) (a) For each fiscal year beginning with fiscal year 2019, the State Tax Commission~~
 778 ~~shall distribute to the Medicaid Expansion Fund, created in Section [26-36b-208](#), any revenues~~
 779 ~~collected from a tax under this section in excess of the revenues collected from a tax under this~~
 780 ~~section in fiscal year 2018.~~

781 ~~—— (b) The distribution in Subsection (6)(a) shall occur after the distributions described in~~
 782 ~~Subsections (5)(b)(i) and (5)(c).] ←Ŝ~~

783 Section ~~Ŝ~~→ [18] 16 ←Ŝ . Section ~~63I-1-226~~ is amended to read:

784 **63I-1-226. Repeal dates, Title 26.**

785 (1) Section [26-1-40](#) is repealed July 1, 2019.

786 (2) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July
 787 1, 2025.

788 (3) Section [26-10-11](#) is repealed July 1, 2020.

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

790 (5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2019.

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

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

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

794 ~~[(9)]~~ (7) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

795 Section ~~Ŝ~~→ [19] 17 ←Ŝ . **Effective date.**

796 If approved by two-thirds of all the members elected to each house, this bill takes effect
 797 upon approval by the governor, or the day following the constitutional time limit of Utah
 798 Constitution, Article VII, Section 8, without the governor's signature, or in the case of a veto,
 799 the date of veto override.

800 Section ~~Ŝ~~→ [20] 18 ←Ŝ . **Coordinating H.B. 325 with H.B. 14 -- Superseding**
 800a **substantive and**

801 **technical amendments.**

802 If this H.B. 325 and H.B. 14, Substance Abuse Treatment Facility Patient Brokering,
 803 both pass and become law, it is the intent of the Legislature that the amendments to Section
 804 26-36b-103 in this bill supersede the amendments to Section 26-36b-103 in H.B. 14, when the
 805 Office of Legislative Research and General Counsel prepares the Utah Code database for
 806 publication.

807 Section ~~Ŝ~~ → [24] 19 ← ~~Ŝ~~ . **Coordinating H.B. 325 with H.B. 472 -- Substantive and**
 807a **technical**

808 **amendments.**

809 If this H.B. 325 and H.B. 472, Medicaid Expansion Revisions, both pass and become
 810 law, it is the intent of the Legislature that the Office of Legislative Research and General
 811 Counsel shall prepare the Utah Code database for publication by making the following
 812 changes:

813 (1) modifying Subsection 26-18-415(3) to read:

814 "(3) (a) The division shall apply for a Medicaid waiver or a state plan amendment with
 815 CMS to implement, within the state Medicaid program, the enhancement waiver program
 816 described in this section within six months after the day on which:

817 (i) the division receives a notice from CMS that the waiver for the Medicaid waiver
 818 expansion submitted under Section 26-18-415, Medicaid waiver expansion, will not be
 819 approved; or

820 (ii) the division withdraws the waiver for the Medicaid waiver expansion submitted
 821 under Section 26-18-415, Medicaid waiver expansion.

822 (b) The division may not apply for a waiver under Subsection (3)(a) while a waiver
 823 request under Section 26-18-415, Medicaid waiver expansion, is pending with CMS.";

824 (2) modifying Subsection 26-36b-201(3) to read:

825 "(3) The first quarterly payment [~~shall not be~~] is not due until at least three months
 826 after the earlier of the effective [~~date~~] dates of the coverage provided through:

827 (a) the health coverage improvement program [~~waiver under Section 26-18-411~~];

828 (b) the enhancement waiver program; or

829 (c) the Medicaid waiver expansion.";

830 (3) modifying Section 26-36b-204 to read:

831 "26-36b-204. Hospital financing of health coverage improvement program

832 **Medicaid waiver -- Hospital share.**833 ~~[(1) For purposes of this section, "hospital share":(a) means]~~834 (1) The hospital share is:835 (a) 45% of the state's net cost of~~[(i)]~~ the health coverage improvement program836 ~~[Medicaid waiver under Section 26-18-411;(ii)], including Medicaid coverage for individuals~~
837 ~~with dependent children up to the federal poverty level designated under Section 26-18-411;~~838 ~~[and]~~839 ~~[(iii) the UPL gap, as that term is defined in Section 26-36b-210;]~~840 (b) 45% of the state's net cost of the enhancement waiver program;841 (c) if the waiver for the Medicaid waiver expansion is approved, \$11,900,000; and842 (d) 45% of the state's net cost of the upper payment limit gap.843 ~~[(b) for the hospital share of the additional coverage under Section 26-18-411;]~~844 (2) (a) The hospital share is capped at no more than \$13,600,000 annually, consisting

845 of:

846 (i) an \$11,900,000 cap ~~[on the hospital's share]~~ for the programs specified in847 Subsections (1)(a)~~[(i) and (ii)]~~ through (c); and848 (ii) a \$1,700,000 cap for the program specified in Subsection ~~[(1)(a)(iii);]~~ (1)(d).849 ~~[(c) for the cap specified in Subsection (1)(b), shall be prorated]~~850 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in851 which the programs specified in ~~§~~ → [Subsection] Subsections ~~←~~ § (1)(a) and ~~§~~ → [(e)] (d) ~~←~~ § are
851a not in effect for the full fiscal852 year~~[-and].~~853 ~~[(d) if the Medicaid program expands in a manner that is greater than the expansion~~854 ~~described in Section 26-18-411, is capped at 33% of the state's share of the cost of the~~855 ~~expansion that is in addition to the program described in Section 26-18-411.]~~856 ~~[(2) The assessment for the private hospital share under Subsection (1) shall be:]~~857 (3) Private hospitals shall be assessed under this chapter for:858 (a) 69% of the portion of the hospital share for the programs specified in Subsections859 (1)(a)~~[(i) and (ii)]~~ through (c); and860 (b) 100% of the portion of the hospital share specified in Subsection ~~[(1)(a)(iii)]~~ (1)(d).861 ~~[(3)]~~ (4) (a) The department shall, on or before October 15, 2017, and on or before862 October 15 of each subsequent year ~~[thereafter]~~, produce a report that calculates the state's net

863 cost of each of the programs described in Subsections (1)(a)[(i) and (ii)] through (c) that are in
 864 effect for that year.

865 (b) If the assessment collected in the previous fiscal year is above or below the [~~private~~
 866 ~~hospital's share of the state's net cost as specified in Subsection (2);~~] hospital share for private
 867 hospitals for the previous fiscal year, the underpayment or overpayment of the assessment by
 868 the private hospitals shall be applied to the fiscal year in which the report [~~was~~] is issued.

869 [~~(4)~~] (5) A Medicaid accountable care organization shall, on or before October 15 of
 870 each year, report to the department the following data from the prior state fiscal year for each
 871 private hospital, state teaching hospital, and non-state government hospital provider that the
 872 Medicaid accountable care organization contracts with:

873 (a) for the traditional Medicaid population[~~, for each private hospital, state teaching~~
 874 ~~hospital, and non-state government hospital provider]:~~

- 875 (i) hospital inpatient payments;
- 876 (ii) hospital inpatient discharges;
- 877 (iii) hospital inpatient days; and
- 878 (iv) hospital outpatient payments; and

879 [~~(b) for the Medicaid population newly eligible under Subsection 26-18-411, for each~~
 880 ~~private hospital, state teaching hospital, and non-state government hospital provider:]~~

881 (b) if the Medicaid accountable care organization enrolls any individuals in the health
 882 coverage improvement program, the enhancement waiver program, or the Medicaid waiver
 883 expansion, for the population newly eligible for any of those programs:

- 884 (i) hospital inpatient payments;
- 885 (ii) hospital inpatient discharges;
- 886 (iii) hospital inpatient days; and
- 887 (iv) hospital outpatient payments.

888 (6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
 889 Administrative Rulemaking Act, provide details surrounding specific content and format for
 890 the reporting by the Medicaid accountable care organization.";

891 (4) modifying Subsection 26-36b-206(3) to read:

892 "(3) The intergovernmental transfer [shall be paid in an amount divided] is apportioned
 893 as follows:

- 925 (3) (a) The fund shall earn interest.
- 926 (b) All interest earned on fund money shall be deposited into the fund.
- 927 (4) (a) A state agency administering the provisions of this chapter may use money from
- 928 the fund to pay the costs ~~[of]~~, not otherwise paid for with federal funds or other revenue
- 929 sources, of:
- 930 (i) the health coverage improvement ~~[Medicaid waiver under Section 26-18-411, and]~~
- 931 program;
- 932 (ii) the enhancement waiver program;
- 933 (iii) the Medicaid waiver expansion; and
- 934 (iv) the outpatient ~~[UPL]~~ upper payment limit supplemental payments under Section
- 935 26-36b-210, ~~[, not otherwise paid for with federal funds or other revenue sources, except that~~
- 936 ~~no]~~.
- 937 (b) A state agency administering the provisions of this chapter may not use:
- 938 (i) funds described in Subsection (2)(b) may be used to pay the cost of private
- 939 outpatient ~~[UPL]~~ upper payment limit supplemental payments~~[;]~~; or
- 940 ~~[(b)]~~ (ii) Money in the fund ~~[may not be used for any other]~~ for any purpose not
- 941 described in Subsection (4)(a).";
- 942 (6) modifying Section 26-36b-209 to read:
- 943 **"26-36b-209. Hospital reimbursement.**
- 944 (1) ~~[The]~~ If the health coverage improvement program, the enhancement waiver
- 945 program, or the Medicaid waiver expansion is implemented by contracting with a Medicaid
- 946 accountable care organization, the department shall, to the extent allowed by law, include, in a
- 947 contract ~~[with a Medicaid accountable care organization]~~ to provide benefits under the health
- 948 coverage improvement program, the enhancement waiver program, or the Medicaid waiver
- 949 expansion, a requirement that the Medicaid accountable care organization reimburse hospitals
- 950 in the accountable care organization's provider network[;] at no less than the Medicaid
- 951 fee-for-service rate.
- 952 (2) If the health coverage improvement program, the enhancement waiver program, or
- 953 the Medicaid waiver expansion is implemented by the department as a fee-for-service program,
- 954 the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.
- 955 (3) Nothing in this section prohibits a Medicaid accountable care organization from

956 paying a rate that exceeds the Medicaid fee-for-service ~~[rates]~~ rate." ~~§~~ → ; ← ~~§~~ and
957 (7) Section 26-36b-211 in this H.B. 325 supersedes Section 26-36b-211 in H.B. 472.
958 Section ~~§~~ → [22] 20 ← ~~§~~ . Coordinating H.B. 325 with S.B. 125 -- Superseding

958a **substantive and**

959 **technical amendments.**

960 If this H.B. 325 and S.B. 125, Child Welfare Amendments, both pass and become law,
961 it is the intent of the Legislature that the amendments to Section 26-36b-103 in this bill
962 supersede the amendments to Section 26-36b-103 in S.B.125, when the Office of Legislative
963 Research and General Counsel prepares the Utah Code database for publication.