None

Other Special Clauses:

Ĥ→ [~~None~~] **This bill provides a coordination clause.** ←Ĥ

Utah Code Sections Affected:

AMENDS:

26-18-18, as last amended by Laws of Utah 2017, Chapter 247

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

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

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

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

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

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

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

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

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

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

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

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

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

ENACTS:

26-18-415, Utah Code Annotated 1953

26-36c-101, Utah Code Annotated 1953

26-36c-102, Utah Code Annotated 1953

26-36c-103, Utah Code Annotated 1953

26-36c-201, Utah Code Annotated 1953

26-36c-202, Utah Code Annotated 1953

26-36c-203, Utah Code Annotated 1953

26-36c-204, Utah Code Annotated 1953

26-36c-205, Utah Code Annotated 1953

26-36c-206, Utah Code Annotated 1953

26-36c-207, Utah Code Annotated 1953

26-36c-208, Utah Code Annotated 1953

26-36c-209, Utah Code Annotated 1953

26-36c-210, Utah Code Annotated 1953

Ĥ→ **Utah Code Sections Affected by Coordination Clause:**

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

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

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

26-18-18. Optional Medicaid expansion.

(1) For purposes of this section[~~,~~]:

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

(b) "PPACA" means the same as that term is defined in Section 31A-1-301.

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

(a) the department expands Medicaid in accordance with Section 26-18-415; or

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

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

(3) (a) The department shall request approval from [~~the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services~~] CMS for waivers from federal statutory and regulatory law necessary to implement the health coverage improvement program under Section 26-18-411.

(b) The health coverage improvement program under Section 26-18-411 is not [~~Medicaid expansion for purposes of this section~~] subject to the requirements in Subsection (2).

Section 2. Section **26-18-415** is enacted to read:

26-18-415. Medicaid waiver expansion.

(1) As used in this section:

(a) "CMS" means the Centers for Medicare and Medicaid Services within the United

States Department of Health and Human Services.

(b) "Expansion population" means individuals:

(i) whose household income is less than 95% of the federal poverty level; and

(ii) who are not eligible for enrollment in the Medicaid program **Ĥ→ , with the exception of the Primary Care Network program, ←Ĥ** on May 8, 2018.

(c) "Federal poverty level" means the same as that term is defined in Section 26-18-411.

(d) "Medicaid waiver expansion" means a Medicaid expansion in accordance with this section.

(2) (a) Before January 1, 2019, the department shall apply to CMS for approval of a waiver or state plan amendment to implement the Medicaid waiver expansion.

(b) The Medicaid waiver expansion shall:

(i) expand Medicaid coverage to eligible individuals whose income is below 95% of the federal poverty level;

(ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for enrolling an individual in the Medicaid program;

(iii) provide Medicaid benefits through the state's Medicaid accountable care organizations in areas where a Medicaid accountable care organization is implemented;

(iv) integrate the delivery of behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model;

(v) include a path to self-sufficiency, including work activities as defined in 42 U.S.C. Sec. 607(d), for qualified adults;

(vi) require an individual who is offered a private health benefit plan by an employer to enroll in the employer's health plan;

(vii) sunset in accordance with Subsection (5)(a); and

(viii) permit the state to close enrollment in the Medicaid waiver expansion if the department has insufficient funding to provide services to additional eligible individuals.

(3) If the Medicaid waiver described in Subsection (1) is approved, the department may only pay the state portion of costs for the Medicaid waiver expansion with appropriations from:

(a) the Medicaid Expansion Fund, created in Section 26-36b-208;

(b) county contributions to the non-federal share of Medicaid expenditures; and

under Subsection (3)(a) is no longer available.

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

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

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

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

(8) "Medicaid waiver expansion" means a Medicaid expansion in accordance with Section 26-18-415.

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

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

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

(i) the Utah State Hospital; or

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

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

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

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

(A) rehabilitation;

(B) psychiatric care;

(C) chemical dependency services; or

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

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

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

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

Section 4. Section **26-36b-201** is amended to read:

26-36b-201. Assessment.

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

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

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

(ii) the assessment under this chapter;

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

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

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

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

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

(b) the Medicaid waiver expansion.

Section 5. Section **26-36b-202** is amended to read:

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

(1) The collecting agent for the assessment imposed under Section 26-36b-201 is the department.

(2) The department is vested with the administration and enforcement of this chapter, [~~including the right to adopt administrative~~] and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

[~~(a) implement and enforce the provisions of this chapter;~~]

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this chapter;

(b) audit records of a facility that:

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

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

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

(2) The department shall:

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

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

Section 6. Section **26-36b-203** is amended to read:

26-36b-203. Quarterly notice.

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

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

Section 7. Section **26-36b-204** is amended to read:

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

[~~(1) For purposes of this section, "hospital share":~~]

(1) The hospital share is:

(a) [~~means~~] 45% of the state's net cost of[~~:(i)~~] the health coverage improvement program [~~Medicaid waiver under Section 26-18-411;(ii)~~], including Medicaid coverage for individuals with dependent children up to the federal poverty level designated under Section 26-18-411; [~~and~~]

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

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

(b) if the waiver for the Medicaid waiver expansion is approved, $11,900,000; and

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

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

(i) an $11,900,000 cap Ĥ→ **[~~on the hospital's share~~]** ←Ĥ for the programs specified in Subsections (1)(a)[~~(i) and (ii)~~] and (b); and

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

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

(b) The department shall prorate the cap described in Subsection (2)(a) in any year in which at least one of the programs specified in Subsection (1) Ĥ→ [~~(a)~~] ←Ĥ are not in effect for the full fiscal year[~~; and~~].

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

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

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

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

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

[~~(3)~~] (4) (a) The department shall, on or before October 15, 2017, and on or before October 15 of each subsequent year [~~thereafter~~], produce a report that calculates the state's net cost of the programs described in Subsections (1)(a)[~~(i) and (ii)~~] and (b) that are in effect for that year.

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

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

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

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments; and

[~~(b) for the Medicaid population newly eligible under Subsection 26-18-411, for each~~

~~private hospital, state teaching hospital, and non-state government hospital provider:~~]

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

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

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

Section 8. Section **26-36b-205** is amended to read:

26-36b-205. Calculation of assessment.

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

(b) A private teaching hospital with more than 425 beds and 60 residents shall pay an assessment rate [~~2.50~~] 2.5 times the uniform rate established under Subsection (1)(c).

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

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

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

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

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

[~~(2) (a) For each state fiscal year, discharges shall be determined using the data from each hospital's Medicare cost report contained in the Centers for Medicare and Medicaid~~

using the same Medicaid provider number; and

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

Section 9. Section **26-36b-206** is amended to read:

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

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

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

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

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

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

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

(a) the state teaching hospital is responsible for:

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

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

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

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

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

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the **Ĥ→ [~~percentages~~] amounts ←Ĥ** designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

Section 10. Section **26-36b-207** is amended to read:

26-36b-207. Penalties and interest.

(1) A hospital that fails to pay [~~any~~] a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this chapter, within the time

chapter [~~shall occur upon the certification by the executive director of the department that the sooner of the following has occurred~~] when the executive director certifies that:

[~~(a) the effective date of any action by Congress that would disqualify~~]

(a) action by Congress is in effect that disqualifies the assessment imposed by this chapter from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

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

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

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

(c) [~~the effective date of~~] a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015[~~; and~~].

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

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

(2) If the assessment is suspended under Subsection (1):

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

(b) the division shall disburse money in the Ĥ→ [~~special revenue fund~~] **Medicaid Expansion Fund** ←Ĥ in accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

(c) the division shall refund any money remaining in the Ĥ→ [~~special revenue fund~~] **Medicaid Expansion Fund** ←Ĥ after the

disbursement described in Subsection (2)(b) that was derived from assessments imposed by this chapter to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years; and

(d) the division shall deposit any money remaining in the Ĥ→ [~~special revenue fund~~] **Medicaid Expansion Fund** ←Ĥ after the disbursements described in Subsections (2)(b) and (c) into the General Fund Ĥ→ **by the end of the fiscal year that the assessment is suspended** ←Ĥ .

Section 15. Section **26-36c-101** is enacted to read:

CHAPTER 36c. MEDICAID EXPANSION HOSPITAL ASSESSMENT ACT

Part 1. General Provisions

26-36c-101. Title.

This chapter is known as the "Medicaid Expansion Hospital Assessment Act."

Section 16. Section **26-36c-102** is enacted to read:

26-36c-102. Definitions.

As used in this chapter:

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

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

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

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

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

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

(5) "Hospital share" means the hospital share described in Section 26-36c-203.

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

(7) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26-36b-208.

(8) "Medicaid waiver expansion" means the same as that term is defined in Section 26-18-415.

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

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

(ii) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this chapter; or

(c) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015.

(2) If the assessment is suspended under Subsection (1):

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

(b) the division shall disburse money in the Ĥ→ **[~~special revenue fund~~]** **Medicaid Expansion Fund** ←Ĥ that was derived from assessments imposed by this chapter in accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

(c) the division shall refund any money remaining in the Ĥ→ **[~~special revenue fund~~]** **Medicaid Expansion Fund** ←Ĥ after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this chapter to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years Ĥ→ **[~~; and~~]** **.**

[~~(d) the division shall deposit any money remaining in the special revenue fund after the disbursements described in Subsections (2)(b) and (c) into the General Fund.~~] ←Ĥ

Section 28. Section **63I-1-226** is amended to read:

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

(1) Section 26-1-40 is repealed July 1, 2019.

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

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

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

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

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

2024.

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

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

(7) Title 26, Chapter 36c, Medicaid Expansion Hospital Assessment Act, is repealed July 1, 2024.

[~~(9)~~] (8) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

Ĥ→ Section 29. Coordinating H.B. 472 with H.B. 14 -- Superseding technical and substantive amendments.

If this H.B. 472 and H.B. 14, Substance Abuse Treatment Facility Patient Brokering, both pass and become law, it is the intent of the Legislature that the amendments to Section 26-36b-103 in this bill supersede the amendments to Section 26-36b-103 in H.B. 14, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.

Section 30. Coordinating H.B. 472 with S.B. 125 -- Superseding technical and substantive amendments.

If this H.B. 472 and S.B. 125, Child Welfare Amendments, both pass and become law, it is the intent of the Legislature that the amendments to Section 26-36b-103 in this bill supersede the amendments to Section 26-36b-103 in S.B. 125, when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication. ←Ĥ

Legislative Review Note
Office of Legislative Research and General Counsel