

MEDICAID EXPANSION REVISIONS

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Robert M. Spendlove

Senate Sponsor: Brian Zehnder

LONG TITLE

General Description:

This bill amends the state Medicaid program to permit an expansion of Medicaid eligibility under certain conditions.

Highlighted Provisions:

This bill:

- ▶ requires the Department of Health to submit a waiver request to the federal government by January 1, 2019, to:
 - provide Medicaid benefits to eligible individuals who are below 95% of the federal poverty level;
 - offer services to Medicaid enrollees through the Medicaid managed care organizations;
 - obtain maximum federal financial participation for the new Medicaid enrollees;
 - require certain qualified adults to meet a work activity requirement; and
 - obtain options for flexibility on enrollment;
- ▶ makes changes to the inpatient hospital assessment;
- ▶ creates a new Medicaid expansion hospital assessment;
- ▶ amends the sunset date for the inpatient hospital assessment and creates a sunset date for the Medicaid expansion hospital assessment; and
- ▶ makes technical changes.

Money Appropriated in this Bill:



28 None

29 Other Special Clauses:

30 H→ [None] This bill provides a coordination clause. ←H

31 Utah Code Sections Affected:

32 AMENDS:

- 33 26-18-18, as last amended by Laws of Utah 2017, Chapter 247
- 34 26-36b-103, as enacted by Laws of Utah 2016, Chapter 279
- 35 26-36b-201, as enacted by Laws of Utah 2016, Chapter 279
- 36 26-36b-202, as enacted by Laws of Utah 2016, Chapter 279
- 37 26-36b-203, as enacted by Laws of Utah 2016, Chapter 279
- 38 26-36b-204, as enacted by Laws of Utah 2016, Chapter 279
- 39 26-36b-205, as enacted by Laws of Utah 2016, Chapter 279
- 40 26-36b-206, as enacted by Laws of Utah 2016, Chapter 279
- 41 26-36b-207, as enacted by Laws of Utah 2016, Chapter 279
- 42 26-36b-208, as enacted by Laws of Utah 2016, Chapter 279
- 43 26-36b-209, as enacted by Laws of Utah 2016, Chapter 279
- 44 26-36b-210, as enacted by Laws of Utah 2016, Chapter 279
- 45 26-36b-211, as enacted by Laws of Utah 2016, Chapter 279
- 46 63I-1-226, as last amended by Laws of Utah 2017, Chapters 177 and 443

47 ENACTS:

- 48 26-18-415, Utah Code Annotated 1953
- 49 26-36c-101, Utah Code Annotated 1953
- 50 26-36c-102, Utah Code Annotated 1953
- 51 26-36c-103, Utah Code Annotated 1953
- 52 26-36c-201, Utah Code Annotated 1953
- 53 26-36c-202, Utah Code Annotated 1953
- 54 26-36c-203, Utah Code Annotated 1953
- 55 26-36c-204, Utah Code Annotated 1953
- 56 26-36c-205, Utah Code Annotated 1953
- 57 26-36c-206, Utah Code Annotated 1953
- 58 26-36c-207, Utah Code Annotated 1953

59 [26-36c-208](#), Utah Code Annotated 1953

60 [26-36c-209](#), Utah Code Annotated 1953

61 [26-36c-210](#), Utah Code Annotated 1953

61a **H→ Utah Code Sections Affected by Coordination Clause:**

61b **26-36b-103, as enacted by Laws of Utah 2016, Chapter 279 ←H**

62

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

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

65 **26-18-18. Optional Medicaid expansion.**

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

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

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

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

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

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

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

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

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

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

87 **26-18-415. Medicaid waiver expansion.**

88 (1) As used in this section:

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

90 States Department of Health and Human Services.

91 (b) "Expansion population" means individuals:

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

93 (ii) who are not eligible for enrollment in the Medicaid program ~~H~~→ , **with the exception**
 93a of the Primary Care Network program, ←~~H~~ on May 8, 2018.

94 (c) "Federal poverty level" means the same as that term is defined in Section
 95 [26-18-411](#).

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

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

100 (b) The Medicaid waiver expansion shall:

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

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

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

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

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

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

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

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

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

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

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

121 (c) any other contributions, funds, or transfers from a non-state agency for Medicaid
 122 expenditures.

123 (4) Medicaid accountable care organizations and counties that elect to integrate care
 124 under Subsection (2)(b)(iv) shall collaborate on enrollment, engagement of patients, and
 125 coordination of services.

126 (5) (a) If federal financial participation for the Medicaid waiver expansion is reduced
 127 below 90%, the authority of the department to implement the Medicaid waiver expansion shall
 128 sunset no later than the next July 1 after the date on which the federal financial participation is
 129 reduced.

130 (b) The department shall close the program to new enrollment if the cost of the
 131 Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are
 132 authorized by the Legislature through an appropriations act adopted in accordance with Title
 133 63J, Chapter 1, Budgetary Procedures Act.

134 (6) If the Medicaid waiver expansion is approved by CMS, the department shall report
 135 to the Social Services Appropriations Subcommittee on or before November 1 of each year that
 136 the Medicaid waiver expansion is operational:

137 (a) the number of individuals who enrolled in the Medicaid waiver program;

138 (b) costs to the state for the Medicaid waiver program;

139 (c) estimated costs for the current and following state fiscal year; and

140 (d) recommendations to control costs of the Medicaid waiver expansion.

141 Section 3. Section **26-36b-103** is amended to read:

142 **26-36b-103. Definitions.**

143 As used in this chapter:

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

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

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

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

151 (b) a similar report adopted by the department by administrative rule, if the report

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

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

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

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

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

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

162 ~~[(5)]~~ (9) "Medicare cost report" means CMS-2552-10, the cost report for electronic
163 filing of hospitals.

164 ~~[(6)]~~ (10) (a) "Non-state government hospital"~~[(a)]~~ means a hospital owned by a
165 non-state government entity~~[, and]~~.

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

167 (i) the Utah State Hospital; or

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

170 ~~[(7)]~~ (11) (a) "Private hospital"~~[(a)]~~ means:

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

173 (ii) a privately owned specialty hospital operating in the state, ~~[which shall include]~~

174 including a privately owned hospital whose inpatient admissions are predominantly ~~H~~→ for ←~~H~~ :

175 (A) rehabilitation;

176 (B) psychiatric care;

177 (C) chemical dependency services; or

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

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

181 ~~[(8)]~~ (12) "State teaching hospital" means a state owned teaching hospital that is part of
182 an institution of higher education.

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

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

187 **26-36b-201. Assessment.**

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

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

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

191 (ii) the assessment under this chapter;

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

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

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

197 (3) The first quarterly payment [~~shall not be~~] is not due until at least three months after
 198 the ~~it~~ earlier of the ~~effective~~ effective ~~date~~ date ~~of~~ of the coverage provided through;

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

200 (b) the Medicaid waiver expansion.

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

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

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

205 (2) The department is vested with the administration and enforcement of this chapter,
 206 [~~including the right to adopt administrative~~] and may make rules in accordance with Title 63G,

207 Chapter 3, Utah Administrative Rulemaking Act, necessary to:

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

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

211 (b) audit records of a facility that:

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

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

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

216 (2) The department shall:

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

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

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

222 **26-36b-203. Quarterly notice.**

223 (1) Quarterly assessments imposed by this chapter shall be paid to the division within
224 15 business days after the original invoice date that appears on the invoice issued by the
225 division.

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

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

228 **26-36b-204. Hospital financing of health coverage improvement program**

229 **Medicaid waiver expansion-- Hospital share.**

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

231 (1) The hospital share is:

232 (a) ~~[means]~~ 45% of the state's net cost of~~[(i)]~~ the health coverage improvement
233 program ~~[Medicaid waiver under Section 26-18-411;(ii)]~~, including Medicaid coverage for
234 individuals with dependent children up to the federal poverty level designated under Section
235 26-18-411; [and]

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

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

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

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

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

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

242a Subsections

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

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

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

246 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in
 247 which at least one of the programs specified in Subsection (1) ~~H→ [(a)] ←H~~ are not in effect for the
 247a full
 248 fiscal year[; and].

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

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

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

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

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

257 ~~[(3)]~~ (4) (a) The department shall, on or before October 15, 2017, and on or before
 258 October 15 of each subsequent year [thereafter], produce a report that calculates the state's net
 259 cost of the programs described in Subsections (1)(a)~~[(i) and (ii)]~~ and (b) that are in effect for
 260 that year.

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

265 ~~[(4)]~~ (5) A Medicaid accountable care organization shall, on or before October 15 of
 266 each year, report to the department the following data from the prior state fiscal year for each
 267 private hospital, state teaching hospital, and non-state government hospital provider that the
 268 Medicaid accountable care organization contracts with:

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

271 (i) hospital inpatient payments;

272 (ii) hospital inpatient discharges;

273 (iii) hospital inpatient days; and

274 (iv) hospital outpatient payments; and

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

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

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

- 280 (i) hospital inpatient payments;
- 281 (ii) hospital inpatient discharges;
- 282 (iii) hospital inpatient days; and
- 283 (iv) hospital outpatient payments.

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

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

288 **26-36b-205. Calculation of assessment.**

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

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

294 (c) The division shall calculate the uniform assessment rate [~~shall be determined using~~
 295 ~~the total number of hospital discharges for assessed private hospitals, the percentages in~~
 296 ~~Subsection 26-36b-204(2), and rule adopted by the department.~~] described in Subsection (1)(a)
 297 by dividing the hospital share for assessed private hospitals, described in Subsection
 298 26-36b-204(1), by the sum of:

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

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

302a **Ĥ→ (d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah**

302b **Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address**
 302c **unforeseen circumstances in the administration of the assessment under this chapter.**

303 [~~(d)~~] (e) ←Ĥ Any quarterly changes to the uniform assessment rate shall be applied
 303a uniformly to

304 all assessed private hospitals.

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

307 ~~Services' Healthcare Cost Report Information System file. The hospital's discharge data will be~~
 308 ~~derived as follows:]~~

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

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

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

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

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

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

322 ~~[(c)]~~ (b) If a hospital is not certified by the Medicare program and is not required to file
 323 a Medicare cost report:

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

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

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

330 ~~[(3)]~~ (4) Except as provided in Subsection ~~[(4)]~~ (5), if a hospital is owned by an
 331 organization that owns more than one hospital in the state:

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

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

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

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

337 (a) the department shall calculate the assessment in the aggregate for the hospitals

338 using the same Medicaid provider number; and

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

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

341 **26-36b-206. State teaching hospital and non-state government hospital**
 342 **mandatory intergovernmental transfer.**

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

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

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

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

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

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

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

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

355 **26-36b-204(1)(a)[~~(i) and (ii)~~] and (b)**; and

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

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

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

359 **~~and (ii)] and (b)~~**; and

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

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

362 Administrative Rulemaking Act, designate:

363 (a) the method of calculating the $\hat{H} \rightarrow$ [~~percentages~~] amounts $\leftarrow \hat{H}$ designated in Subsection

363a (3); and

364 (b) the schedule for the intergovernmental transfers.

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

366 **26-36b-207. Penalties and interest.**

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

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

369 required by this chapter, shall pay penalties described in this section, in addition to the
 370 assessment or intergovernmental transfer~~[-, and interest established by the department].~~

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

374 ~~[(b)]~~ (2) If a hospital fails to timely pay the full amount of a quarterly assessment or the
 375 mandated intergovernmental transfer, the department shall add to the assessment or
 376 intergovernmental transfer:

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

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

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

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

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

387 Section 11. Section **26-36b-208** is amended to read:

388 **26-36b-208. Medicaid Expansion Fund.**

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

391 (2) The fund consists of:

392 (a) assessments collected under this chapter;

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

394 (c) savings attributable to the health coverage improvement program [~~under Section~~
 395 [26-18-411](#)] as determined by the department;

396 (d) savings attributable to the Medicaid waiver expansion as determined by the
 397 department;

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

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

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

404 (h) interest earned on money in the fund; and

405 ~~[(g)]~~ (i) additional amounts as appropriated by the Legislature.

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

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

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

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

413 (ii) the Medicaid waiver expansion; and

414 (iii) the outpatient [UPE] upper payment limit supplemental payments under Section
415 26-36b-210~~[, not otherwise paid for with federal funds or other revenue sources, except that~~
416 ~~no]~~.

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

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

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

422 Section 12. Section ~~26-36b-209~~ is amended to read:

423 **~~26-36b-209. Hospital reimbursement.~~**

424 (1) ~~[The]~~ If the health coverage improvement program or the Medicaid waiver
425 expansion is implemented by contracting with a Medicaid accountable care organization, the
426 department shall, to the extent allowed by law, include, in a contract [with a Medicaid
427 accountable care organization] to provide benefits under the health coverage improvement
428 program or the Medicaid waiver expansion, a requirement that the Medicaid accountable care
429 organization reimburse hospitals in the accountable care organization's provider network~~[-]~~ at
430 no less than the Medicaid fee-for-service rate.

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

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

436 Section 13. Section **26-36b-210** is amended to read:

437 **26-36b-210. Outpatient upper payment limit supplemental payments.**

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

441 ~~[(2)]~~ (1) Beginning on the effective date of the assessment imposed under this chapter,
 442 and for each subsequent fiscal year ~~[thereafter]~~, the department shall implement an outpatient
 443 upper payment limit program for private hospitals that shall supplement the reimbursement to
 444 private hospitals in accordance with Subsection ~~[(3)]~~ (2).

445 ~~[(3)]~~ (2) The division shall ensure that supplemental payment to Utah private hospitals
 446 under Subsection ~~[(2) shall]~~ (1):

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

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

449 ~~[(4)]~~ (3) The department shall use the same outpatient data ~~[used to calculate the UPL~~
 450 ~~gap under Subsection (1) shall be the same outpatient data used]~~ to allocate the payments under
 451 Subsection ~~[(3)]~~ (2) and to calculate the upper payment limit gap.

452 ~~[(5)]~~ (4) The supplemental payments to private hospitals under Subsection ~~[(2) shall~~
 453 ~~be]~~ (1) are payable for outpatient hospital services provided on or after the later of:

454 (a) July 1, 2016;

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

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

459 Section 14. Section **26-36b-211** is amended to read:

460 **26-36b-211. Suspension of assessment.**

461 (1) The ~~[repeal of the]~~ department shall suspend the assessment imposed by this

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

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

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

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

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

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

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

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

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

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

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

489 (b) the division shall disburse money in the ~~Ĥ~~→ ~~[special revenue fund]~~ Medicaid
 489a Expansion Fund ←~~Ĥ~~ in accordance with
 490 the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by
 491 CMS due to the repeal of the assessment;

492 (c) the division shall refund any money remaining in the ~~Ĥ~~→ ~~[special revenue fund]~~
 492a Medicaid Expansion Fund ←~~Ĥ~~ after the

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

496 (d) the division shall deposit any money remaining in the ~~H→~~ [special revenue fund]
 496a Medicaid Expansion Fund ~~←H~~ after the
 497 disbursements described in Subsections (2)(b) and (c) into the General Fund ~~H→~~ by the end of the
 497a fiscal year that the assessment is suspended ~~←H~~ .

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

499 **CHAPTER 36c. MEDICAID EXPANSION HOSPITAL ASSESSMENT ACT**

500 **Part 1. General Provisions**

501 **26-36c-101. Title.**

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

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

504 **26-36c-102. Definitions.**

505 As used in this chapter:

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

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

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

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

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

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

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

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

520 (7) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in
 521 Section [26-36b-208](#).

522 (8) "Medicaid waiver expansion" means the same as that term is defined in Section
 523 [26-18-415](#).

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

526 (10) (a) "Non-state government hospital" means a hospital owned by a non-state
527 government entity.

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

529 (i) the Utah State Hospital; or

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

532 (11) (a) "Private hospital" means:

533 (i) a privately owned general acute hospital operating in the state as defined in Section
534 26-21-2; or

535 (ii) a privately owned specialty hospital operating in the state, including a privately
536 owned hospital for which inpatient admissions are predominantly:

537 (A) rehabilitation;

538 (B) psychiatric;

539 (C) chemical dependency; or

540 (D) long-term acute care services.

541 (b) "Private hospital" does not include a facility for residential treatment as defined in
542 Section 62A-2-101.

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

545 Section 17. Section **26-36c-103** is enacted to read:

546 **26-36c-103. Application.**

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

550 (a) state law;

551 (b) ad valorem property tax requirement;

552 (c) sales or use tax requirement; or

553 (d) other requirements imposed by taxes, fees, or assessments, whether imposed or
554 sought to be imposed, by the state or any political subdivision of the state.

555 (2) A hospital paying an assessment under this chapter may include the assessment as
 556 an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement
 557 formula.

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

559 (a) license a hospital for revenue;

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

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

562 Section 18. Section **26-36c-201** is enacted to read:

563 **Part 2. Assessment and Collection**

564 **26-36c-201. Assessment.**

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

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

567 (i) the waiver for the Medicaid waiver expansion; and

568 (ii) the assessment under this chapter;

569 (b) in the amount designated in Sections [26-36c-204](#) and [26-36c-205](#); and

570 (c) in accordance with Section [26-36c-202](#).

571 (2) Subject to Subsection [26-36c-202](#)(4), the assessment imposed by this chapter is due
 572 and payable on the last day of each quarter.

573 (3) The first quarterly payment is not due until at least three months after the effective
 574 date of the coverage provided through the Medicaid waiver expansion.

575 Section 19. Section **26-36c-202** is enacted to read:

576 **26-36c-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**

577 (1) The department shall act as the collecting agent for the assessment imposed under
 578 Section [26-36c-201](#).

579 (2) The department shall administer and enforce the provisions of this chapter, and may
 580 make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act,
 581 necessary to:

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

584 (b) audit records of a facility that:

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

586 (ii) does not file a Medicare cost report; and
587 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
588 Medicare cost report.

589 (3) The department shall:

590 (a) administer the assessment in this part separately from the assessments in Chapter
591 36a, Hospital Provider Assessment Act, and Chapter 36b, Inpatient Hospital Assessment Act;
592 and

593 (b) deposit assessments collected under this chapter into the Medicaid Expansion Fund.

594 (4) (a) Hospitals shall pay the quarterly assessments imposed by this chapter to the
595 division within 15 business days after the original invoice date that appears on the invoice
596 issued by the division.

597 (b) The department may make rules creating requirements to allow the time for paying
598 the assessment to be extended.

599 Section 20. Section **26-36c-203** is enacted to read:

600 **26-36c-203. Hospital share.**

601 (1) The hospital share is 100% of the state's net cost of the Medicaid waiver expansion,
602 after deducting appropriate offsets and savings expected as a result of implementing the
603 Medicaid waiver expansion, including savings from:

604 (a) the Primary Care Network program;

605 (b) the health coverage improvement program, as defined in Section [26-18-411](#);

606 (c) the state portion of inpatient prison medical coverage;

607 (d) behavioral health coverage; and

608 (e) county contributions to the non-federal share of Medicaid expenditures.

609 (2) (a) The hospital share is capped at no more than \$25,000,000 annually.

610 (b) The division shall prorate the cap specified in Subsection (2)(a) in any year in
611 which the Medicaid waiver expansion is not in effect for the full fiscal year.

612 Section 21. Section **26-36c-204** is enacted to read:

613 **26-36c-204. Hospital financing of Medicaid waiver expansion.**

614 (1) Private hospitals shall be assessed under this chapter for the portion of the hospital
615 share described in Section [26-36c-209](#).

616 (2) The department shall, on or before October 15, 2019, and on or before October 15

617 of each subsequent year, produce a report that calculates the state's net cost of the Medicaid
618 waiver expansion.

619 (3) If the assessment collected in the previous fiscal year is above or below the hospital
620 share for private hospitals for the previous fiscal year, the division shall apply the
621 underpayment or overpayment of the assessment by the private hospitals to the fiscal year in
622 which the report is issued.

623 Section 22. Section **26-36c-205** is enacted to read:

624 **26-36c-205. Calculation of assessment.**

625 (1) (a) Except as provided in Subsection (1)(b), each private hospital shall pay an
626 annual assessment due on the last day of each quarter in an amount calculated by the division at
627 a uniform assessment rate for each hospital discharge, in accordance with this section.

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

630 (c) The division shall calculate the uniform assessment rate described in Subsection
631 (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection
632 26-36c-204(1), by the sum of:

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

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

637 (d) The division may make rules in accordance with Title 63G, Chapter 3, Utah
638 Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address
639 unforeseen circumstances in the administration of the assessment under this chapter.

640 (e) The division shall apply any quarterly changes to the uniform assessment rate
641 uniformly to all assessed private hospitals.

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

644 (a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year
645 ending between July 1, 2015, and June 30, 2016; and

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

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

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

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

653 (b) If a hospital is not certified by the Medicare program and is not required to file a
654 Medicare cost report:

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

657 (ii) the division shall determine the hospital's discharges from the information
658 submitted under Subsection (3)(c)(i); and

659 (iii) if the hospital fails to submit discharge information, the division shall audit the
660 hospital's records and may impose a penalty equal to 5% of the calculated assessment.

661 (4) Except as provided in Subsection (5), if a hospital is owned by an organization that
662 owns more than one hospital in the state:

663 (a) the division shall calculate the assessment for each hospital separately; and

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

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

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

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

669 Section 23. Section **26-36c-206** is enacted to read:

670 **26-36c-206. State teaching hospital and non-state government hospital mandatory**
671 **intergovernmental transfer.**

672 (1) A state teaching hospital and a non-state government hospital shall make an
673 intergovernmental transfer to the Medicaid Expansion Fund, in accordance with this section.

674 (2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer
675 beginning on the later of CMS approval of:

676 (a) the waiver for the Medicaid waiver expansion; or

677 (b) the assessment for private hospitals in this chapter.

678 (3) The intergovernmental transfer is apportioned between the non-state government

679 hospitals as follows:

680 (a) the state teaching hospital shall pay for the portion of the hospital share described in
681 Section 26-36c-209; and

682 (b) non-state government hospitals shall pay for the portion of the hospital share
683 described in Section 26-36c-209.

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

686 (a) the method of calculating the amounts designated in Subsection (3); and

687 (b) the schedule for the intergovernmental transfers.

688 Section 24. Section **26-36c-207** is enacted to read:

689 **26-36c-207. Penalties.**

690 (1) A hospital that fails to pay a quarterly assessment, make the mandated
691 intergovernmental transfer, or file a return as required under this chapter, within the time
692 required by this chapter, shall pay penalties described in this section, in addition to the
693 assessment or intergovernmental transfer.

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

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

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

701 (i) any unpaid quarterly assessment or intergovernmental transfer; and

702 (ii) any unpaid penalty assessment.

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

705 Section 25. Section **26-36c-208** is enacted to read:

706 **26-36c-208. Hospital reimbursement.**

707 (1) If the Medicaid waiver expansion is implemented by contracting with a Medicaid
708 accountable care organization, the department shall, to the extent allowed by law, include in a
709 contract to provide benefits under the Medicaid waiver expansion a requirement that the

710 accountable care organization reimburse hospitals in the accountable care organization's
711 provider network at no less than the Medicaid fee-for-service rate.

712 (2) If the Medicaid waiver expansion is implemented by the department as a
713 fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid
714 fee-for-service rate.

715 (3) Nothing in this section prohibits the department or a Medicaid accountable care
716 organization from paying a rate that exceeds the Medicaid fee-for-service rate.

717 Section 26. Section **26-36c-209** is enacted to read:

718 **26-36c-209. Hospital financing of the hospital share.**

719 (1) For the first two full fiscal years that the assessment is in effect, the department
720 shall:

721 (a) assess private hospitals under this chapter for 69% of the hospital share for the
722 Medicaid waiver expansion;

723 (b) require the state teaching hospital to make an intergovernmental transfer under this
724 chapter for 30% of the hospital share for the Medicaid waiver expansion; and

725 (c) require non-state government hospitals to make an intergovernmental transfer under
726 this chapter for 1% of the hospital share for the Medicaid waiver expansion.

727 (2) (a) At the beginning of the third full fiscal year that the assessment is in effect, and
728 at the beginning of each subsequent fiscal year, the department may set a different percentage
729 share for private hospitals, the state teaching hospital, and non-state government hospitals by
730 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, with
731 input from private hospitals and private teaching hospitals.

732 (b) If the department does not set a different percentage share under Subsection (2)(a),
733 the percentage shares in Subsection (1) shall apply.

734 Section 27. Section **26-36c-210** is enacted to read:

735 **26-36c-210. Suspension of assessment.**

736 (1) The department shall suspend the assessment imposed by this chapter when the
737 executive director certifies that:

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

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

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

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

747 (c) a change is in effect that reduces the aggregate hospital inpatient and outpatient
 748 payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1,
 749 2015.

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

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

753 (b) the division shall disburse money in the ~~H→ [special revenue fund]~~ **Medicaid**
 753a **Expansion Fund** ←H that was derived from
 754 assessments imposed by this chapter in accordance with the requirements in Subsection
 755 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the
 756 assessment;

757 (c) the division shall refund any money remaining in the ~~H→ [special revenue fund]~~
 757a **Medicaid Expansion Fund** ←H after the
 758 disbursement described in Subsection (2)(b) that was derived from assessments imposed by
 759 this chapter to the hospitals in proportion to the amount paid by each hospital for the last three
 760 fiscal years ~~H→ [; and]~~ .

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

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

764 **63I-1-226. Repeal dates, Title 26.**

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

766 (2) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July
 767 1, 2025.

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

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

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

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

772 2024.

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

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

775 (7) Title 26, Chapter 36c, Medicaid Expansion Hospital Assessment Act, is repealed

776 July 1, 2024.

777 [~~(9)~~ (8) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

777a **Ĥ→ Section 29. Coordinating H.B. 472 with H.B. 14 -- Superseding technical and substantive**
 777b **amendments.**

777c **If this H.B. 472 and H.B. 14, Substance Abuse Treatment Facility Patient Brokering, both pass**
 777d **and become law, it is the intent of the Legislature that the amendments to Section 26-36b-103**
 777e **in this bill supersede the amendments to Section 26-36b-103 in H.B. 14, when the Office of**
 777f **Legislative Research and General Counsel prepares the Utah Code database for**
 777g **publication.**

777h **Section 30. Coordinating H.B. 472 with S.B. 125 -- Superseding technical and substantive**
 777i **amendments.**

777j **If this H.B. 472 and S.B. 125, Child Welfare Amendments, both pass and become law, it is the**
 777k **intent of the Legislature that the amendments to Section 26-36b-103 in this bill supersede the**
 777l **amendments to Section 26-36b-103 in S.B. 125, when the Office of Legislative Research and**
 777m **General Counsel prepares the Utah Code database for publication.** ←Ĥ

Legislative Review Note
Office of Legislative Research and General Counsel