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H.B. 325
2nd Sub. (Gray)

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 provide enhanced benefits for certain individuals;
- describes the enhanced benefits;
- 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.

2nd Sub. H.B. 325

Utah Code Sections Affected:

AMENDS:

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

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

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

32B-2-301, as last amended by Laws of Utah 2017, Chapter 159

59-14-204, as last amended by Laws of Utah 2016, Chapter 168

ENACTS:

26-18-415, Utah Code Annotated 1953

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

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

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

(1) For purposes of this section:

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

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

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

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

States Department of Health and Human Services.

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

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

(e) (i) "Health coverage improvement program" means the health coverage improvement program described in Subsections (2) through (6)(a).

(ii) "Health coverage improvement program" does not include the program described in Subsection (6)(b).

[~~(d)~~] (f) "Homeless":

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

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

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

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

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

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

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

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

(i) through:

(A) the traditional fee for service Medicaid model in counties without Medicaid accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented; and

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

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

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

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

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

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

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

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

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

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

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

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

(c) An individual who qualifies for Medicaid coverage under Subsections (3)(a) and (b) may remain on the Medicaid program for a 12-month certification period as defined by the

department. Eligibility changes made by the department under Subsection (1)[~~(c)~~](g) or (3)(b) shall not apply to an individual during the 12-month certification period.

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

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

(a) the number of individuals who enrolled in Medicaid under Subsection (3);

(b) the state cost of providing Medicaid to individuals enrolled under Subsection (3); and

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

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

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

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

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

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

(9) The department shall:

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

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

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

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

(10) If the enhancement waiver program is implemented, the department:

(a) may not accept any new enrollees into the health coverage improvement program after the day on which the enhancement waiver program is implemented;

(b) shall transition all individuals who are enrolled in the health coverage improvement program into the enhancement waiver program;

(c) shall suspend the health coverage improvement program within one year after the day on which the enhancement waiver program is implemented;

(d) shall, within one year after the day on which the enhancement waiver program is implemented, use all appropriations for the health coverage improvement program to implement the enhancement waiver program; and

(e) may not allow any waiver for the health coverage improvement program to lapse while the health coverage improvement program is suspended under Subsection (10)(c).

(11) If, after the enhancement waiver program takes effect, the enhancement waiver program is repealed or suspended by either the state or federal government, the department shall reinstate the health coverage improvement program and continue to accept new enrollees into the health coverage improvement program in accordance with the provisions of this section.

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

26-18-415. Primary Care Network enhancement waiver program.

(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) "Federal poverty level" means the poverty guidelines established by the secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec. 9902(2).

(c) "Health coverage improvement program" means the same as that term is defined in Section 26-18-411.

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

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

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

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

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

(g) "Primary Care Network" means the state primary care network program created by the Medicaid primary care network demonstration waiver obtained under Section 26-18-3.

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

(3) In addition to the benefits offered under the Primary Care Network, an individual who is eligible for the enhancement waiver program may receive the following benefits under the enhancement waiver program:

(a) diagnostic testing and procedures;

(b) medical specialty care;

(c) inpatient hospital services;

(d) outpatient hospital services;

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

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

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

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

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

(c) the individual meets the eligibility criteria established by the department under Subsection (5).

(5) (a) Based on available funding and approval from CMS, the department shall determine the criteria for an individual to qualify for the enhancement waiver program, based on the following priority:

(i) an individual who qualifies for the health coverage improvement program;

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

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

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

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

(6) The department may request a modification of the income eligibility ceiling and the eligibility criteria under Subsection (5) from CMS each fiscal year based on enrollment in the enhancement waiver program, projected enrollment in the enhancement waiver program, costs to the state, and the state budget.

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

(8) In accordance with Subsections 26-18-411(10) and (11), the department may use funds that have been appropriated for the health coverage improvement program described in Section 26-18-411 to implement the enhancement waiver program.

(9) If the department expands the state Medicaid program to the optional population under Section 26-18-18, the department:

(a) except as provided in Subsection (10), may not accept any new enrollees into the enhancement waiver program after the day on which the expansion under Section 26-18-18 is

effective;

(b) shall suspend the enhancement waiver program within one year after the day on which the expansion under Section 26-18-18 is effective; and

(c) may not allow the waiver for the enhancement waiver program submitted under Subsection (2) to lapse while the enhancement waiver program is suspended under Subsection (9)(b).

(10) If, after the expansion to the optional population described in Subsection (9) takes effect, the expansion to the optional population is repealed by either the state or the federal government, the department shall reinstate the enhancement waiver program and continue to accept new enrollees into the enhancement waiver program in accordance with the provisions of this section.

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

26-36b-102. Application.

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

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

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

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

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

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

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

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

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

(a) license a hospital for revenue;

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

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

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

26-36b-103. Definitions.

As used in this chapter:

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

(2) "CMS" means the [~~same as that term is defined in Section 26-18-411~~] 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) "Enhancement waiver program" means the program established by the Primary Care Network enhancement waiver under Section 26-18-415.

(6) "Health coverage improvement program" means the 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.

[~~(5)~~] (8) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

[~~(6)~~] (9) (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)~~] (10) (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 for:

(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)~~] (11) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

(12) "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 5. 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 effective date of the coverage provided through:

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

(b) the enhancement waiver program.

Section 6. 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 7. 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 8. Section **26-36b-204** is amended to read:

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

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

(1) The hospital share is 45% of the state's net cost of:

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

(ii) Medicaid coverage for individuals with dependent children up to the federal

poverty level designated under Section 26-18-411; [~~and~~]

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

(iii) the enhancement waiver program; and

(iv) the upper payment limit gap.

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

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

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

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

[~~(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 the programs specified in Subsection (1)(a) are not in effect for the full fiscal year[~~;~~ ~~and~~].

[~~(d)~~] (c) [~~if~~] If the Medicaid program expands in a manner that is greater than the expansion described in Section 26-18-411[~~,~~] and the enhancement described in Section 26-18-415, the hospital share is capped at 33% of the state's share of the cost of the expansion or enhancement that is in addition to the [~~program~~] programs described in Section 26-18-411 or Section 26-18-415.

[~~(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 for the programs specified in Subsections (1)(a)(i) [~~and (ii)~~] through (iii); and

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

[~~(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 each of the programs described in Subsections (1)(a)(i) [~~and (ii)~~] through (iv).

(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 enhancement waiver program, 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.

Section 9. 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 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 uniform assessment rate described in Subsection (1)(a) 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.~~] 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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The [~~intergovernmental transfer shall be paid~~] 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;

(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)~~] through (iii); and

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

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

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

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

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

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

(b) the schedule for the intergovernmental transfers.

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

26-36b-207. Penalties.

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

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

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

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

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

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

(B) any unpaid penalty assessment.

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

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

26-36b-208. Medicaid Expansion Fund.

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

(2) The fund consists of:

(a) assessments collected under this chapter;

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

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

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

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

(f) the amount transferred under Subsection 32B-2-301(7);

(g) the amount transferred under Subsection 59-14-204(6);

(h) interest earned on money in the fund;

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

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

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

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

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

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

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

(iii) the enhancement waiver program.

(b) No funds described in Subsection (2)(b) may be used to pay the cost of outpatient

[~~UPL~~] upper payment limit supplemental payments.

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

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

26-36b-209. Hospital reimbursement.

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

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

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

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

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

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

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

[~~(3)~~] (2) The supplemental payment to Utah private hospitals under Subsection [~~(2) shall~~] (1):

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

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

(4) The department shall use the same outpatient data [~~used to calculate the UPL gap under Subsection (1) shall be the same outpatient data used~~] to allocate the payments under

Subsection [~~(3)~~] (2) and to calculate the upper payment limit gap.

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

(a) July 1, 2016;

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

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

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

26-36b-211. Repeal of assessment.

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

(a) the executive director certifies that:

[~~(a)~~] (i) [~~the effective date of any~~] action by Congress [~~that would disqualify~~] 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)~~] (ii) [~~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)~~] (A) [~~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)~~] (B) [~~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)~~] (iii) [~~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~~] or

[~~(d)~~] (b) [~~the sunset of~~] this chapter is repealed 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 repealed under Subsection (1):

(a) the department shall disburse money in the special revenue fund 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;

(b) any money remaining in the special revenue fund after the disbursement described in Subsection (2)(a) that was derived from assessments imposed by this chapter shall be refunded to the hospitals in proportion to the amount paid by each hospital; and

(c) any money remaining in the special revenue fund after the disbursements described in Subsection (2)(a) and (b) shall be deposited into the General Fund.

Section 16. Section **32B-2-301** is amended to read:

32B-2-301. State property -- Liquor Control Fund -- Markup Holding Fund.

(1) The following are property of the state:

(a) the money received in the administration of this title, except as otherwise provided; and

(b) property acquired, administered, possessed, or received by the department.

(2) (a) There is created an enterprise fund known as the "Liquor Control Fund."

(b) Except as provided in Sections 32B-3-205 and 32B-2-304, money received in the administration of this title shall be transferred to the Liquor Control Fund.

(3) (a) There is created an enterprise fund known as the "Markup Holding Fund."

(b) In accordance with Section 32B-2-304, the State Tax Commission shall deposit revenue remitted to the State Tax Commission from the markup imposed under Section 32B-2-304 into the Markup Holding Fund.

(c) Money deposited into the Markup Holding Fund may be expended:

(i) to the extent appropriated by the Legislature; and

(ii) to fund the deposits required by Subsection 32B-2-304(4) and Subsection 32B-2-305(4).

(4) The department may draw from the Liquor Control Fund only to the extent

appropriated by the Legislature or provided for by statute, except that the department may draw by warrant without an appropriation from the Liquor Control Fund for an expenditure that is directly incurred by the department:

(a) to purchase an alcoholic product;

(b) to transport an alcoholic product from the supplier to a warehouse of the department; and

(c) for variances related to an alcoholic product.

(5) (a) As used in this Subsection (5), "base budget" means the same as that term is defined in legislative rule.

(b) The department's base budget shall include as an appropriation from the Liquor Control Fund:

(i) credit card related fees paid by the department;

(ii) package agency compensation; and

(iii) the department's costs of shipping and warehousing alcoholic products.

(6) Before the transfer required by Subsection (7), the department may retain each fiscal year from the Liquor Control Fund $1,000,000 that the department may use for:

(a) capital equipment purchases;

(b) salary increases for department employees;

(c) performance awards for department employees; or

(d) information technology enhancements because of changes or trends in technology.

(7) [~~The~~] (a) Except as provided in Subsection (7)(b), the department shall transfer annually from the Liquor Control Fund and the State Tax Commission shall transfer annually from the Markup Holding Fund to the General Fund a sum equal to the amount of net profit earned from the sale of liquor since the preceding transfer of money under this Subsection (7). The transfers shall be calculated by no later than September 1 and made by no later than September 30 after a fiscal year. The Division of Finance may make year-end closing entries in the Liquor Control Fund and the Markup Holding Fund in order to comply with Subsection 51-5-6(2).

(b) Subject to Subsection (7)(c), and in accordance with Subsection 26-36b-208(2)(f), for each fiscal year beginning in fiscal year 2019, the department and the Division of Finance shall transfer to the Medicaid Expansion Fund, created in Section 26-36b-208, any amount

described in Subsection (7)(a) in excess of the amount transferred by the department or the Division of Finance in fiscal year 2018.

(c) The annual transfer to the Medicaid Expansion Fund, described in Subsection (7)(b), shall be capped at $10,000,000.

(8) (a) By the end of each day, the department shall:

(i) make a deposit to a qualified depository, as defined in Section 51-7-3; and

(ii) report the deposit to the state treasurer.

(b) A commissioner or department employee is not personally liable for a loss caused by the default or failure of a qualified depository.

(c) Money deposited in a qualified depository is entitled to the same priority of payment as other public funds of the state.

(9) If the cash balance of the Liquor Control Fund is not adequate to cover a warrant drawn against the Liquor Control Fund by the department, the cash resources of the General Fund may be used to the extent necessary. At no time may the fund equity of the Liquor Control Fund fall below zero.

Section 17. Section **59-14-204** is amended to read:

59-14-204. Tax basis -- Rate -- Future increase -- Cigarette Tax Restricted Account -- Appropriation and expenditure of revenues.

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

(2) The rates of the tax levied under Subsection (1) are, beginning on July 1, 2010:

(a) 8.5 cents on each cigarette, for all cigarettes weighing not more than three pounds per thousand cigarettes; and

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

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

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

(5) (a) There is created within the General Fund a restricted account known as the

"Cigarette Tax Restricted Account."

(b) The Cigarette Tax Restricted Account consists of:

(i) the first $7,950,000 of the revenues collected from a tax under this section; and

(ii) any other appropriations the Legislature makes to the Cigarette Tax Restricted Account.

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

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

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

(iii) $2,000,000 to the University of Utah Health Sciences Center for the Huntsman Cancer Institute to be expended for cancer research; and

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

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

(6) (a) For each fiscal year beginning with fiscal year 2019, the State Tax Commission shall distribute to the Medicaid Expansion Fund, created in Section 26-36b-208, any revenues collected from a tax under this section in excess of the revenues collected from a tax under this section in fiscal year 2018.

(b) The distribution in Subsection (6)(a) shall occur after the distributions described in Subsections (5)(b)(i) and (5)(c).

Section 18. **Effective date.**

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