1 # HEALTH CARE REVISIONS

2 2016 GENERAL SESSION

3 STATE OF UTAH

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20

21 **LONG TITLE**

22 **General Description:**

23 This bill implements a health coverage improvement program through Medicaid waiver
24 authority granted to states before the federal Patient Protection and Affordable Care
25 Act, and establishes a funding mechanism for the waiver program.

26 **Highlighted Provisions:**

27 This bill:

28 ▸ authorizes a preferred drug list for psychotropic drugs with an override for dispense

29 as written;
30 ▸ establishes targets for savings from the preferred drug list;
31 ▸ authorizes the Department of Health to apply for waivers from federal law necessary
32 to implement a health coverage improvement program in Medicaid;
33 ▸ distinguishes the health coverage improvement program from Medicaid expansion
34 under the Affordable Care Act;
35 ▸ defines terms;
36 ▸ describes the Medicaid waiver request;
37 ▸ permits a waiver enrollee to maintain Medicaid coverage for 12 months;
38 ▸ provides eligibility criteria;
39 ▸ amends the county matching funds for enrollees in the health coverage improvement
40 program;
41 ▸ expands Medicaid eligibility for adults with dependent children;
42 ▸ requires the Department of Health to apply for a waiver for the existing Medicaid
43 population and the enrollees in the health coverage improvement program to allow
44 substance abuse treatment at facilities with no bed capacity limits;
45 ▸ enhances the efficiency of Medicaid enrollment for adults released from
46 incarceration;
47 ▸ establishes an inpatient private hospital assessment to fund the Medicaid waiver;
48 ▸ establishes a mandatory intergovernmental transfer of funds from the state teaching
49 hospital and certain other government owned hospitals to fund the Medicaid waiver;
50 ▸ authorizes the Public Employees' Benefit and Insurance Program to provide services
51 for drugs and devices for certain individuals at the request of a procurement unit;
52 and
53 ▸ requires the Department of Health to study methods to increase coverage to
54 uninsured low income adults with children and to maximize the use of employer
55 sponsored coverage.
56 **Money Appropriated in this Bill:**

57 This bill appropriates $2,508,500 ongoing General Fund from other programs to the
58 Medicaid Expansion Fund and makes changes to other funds.
59 **Other Special Clauses:**
60 None
61 **Utah Code Sections Affected:**
62 AMENDS:
63 **26-18-2.4**, as last amended by Laws of Utah 2012, Chapters 242 and 343
64 **26-18-18**, as last amended by Laws of Utah 2015, Chapter 283
65 **49-20-401**, as last amended by Laws of Utah 2015, Chapter 155
66 **63I-1-226**, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258
67 ENACTS:
68 **26-18-411**, Utah Code Annotated 1953
69 **26-36b-101**, Utah Code Annotated 1953
70 **26-36b-102**, Utah Code Annotated 1953
71 **26-36b-103**, Utah Code Annotated 1953
72 **26-36b-201**, Utah Code Annotated 1953
73 **26-36b-202**, Utah Code Annotated 1953
74 **26-36b-203**, Utah Code Annotated 1953
75 **26-36b-204**, Utah Code Annotated 1953
76 **26-36b-205**, Utah Code Annotated 1953
77 **26-36b-206**, Utah Code Annotated 1953
78 **26-36b-207**, Utah Code Annotated 1953
79 **26-36b-208**, Utah Code Annotated 1953
80 **26-36b-209**, Utah Code Annotated 1953
81 **26-36b-210**, Utah Code Annotated 1953
82 **26-36b-211**, Utah Code Annotated 1953
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84 *Be it enacted by the Legislature of the state of Utah:*

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

86 **26-18-2.4. Medicaid drug program -- Preferred drug list.**

87 (1) A Medicaid drug program developed by the department under Subsection
88 26-18-2.3(2)(f):

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

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

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

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

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

98 (d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and
99 except as provided in Subsection (3), shall immediately implement the prior authorization
100 requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:

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

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

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

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

111 (ii) provide for the dispensing of a limited supply of a requested drug as determined
112 appropriate by the department in an emergency situation, if the request for an override is

113 received outside of the department's normal business hours; and
114 (iii) require the health care provider to provide the department with documentation of
115 the medical need for the preferred drug list override in accordance with criteria established by
116 the department in consultation with the Pharmacy and Therapeutics Committee.
117 (2) (a) For purposes of this Subsection (2):
118 (i) "Immunosuppressive drug":
119 (A) means a drug that is used in immunosuppressive therapy to inhibit or prevent
120 activity of the immune system to aid the body in preventing the rejection of transplanted organs
121 and tissue; and
122 (B) does not include drugs used for the treatment of autoimmune disease or diseases
123 that are most likely of autoimmune origin.
124 [~~(ii) "Psychotropic drug" means the following classes of drugs: atypical anti-psychotic,~~
125 ~~anti-depressants, anti-convulsant/mood stabilizer, anti-anxiety, attention deficit hyperactivity~~
126 ~~disorder stimulants, or sedative/hypnotics.~~]
127 [~~(iii)~~] (ii) "Stabilized" means a health care provider has documented in the patient's
128 medical chart that a patient has achieved a stable or steadfast medical state within the past 90
129 days using a particular psychotropic drug.
130 (b) A preferred drug list developed under the provisions of this section may not
131 include[~~: (i) except as provided in Subsection (2)(e), a psychotropic or anti-psychotic drug; or~~
132 ~~(ii)~~] an immunosuppressive drug.
133 (c) The state Medicaid program shall reimburse for a prescription for an
134 immunosuppressive drug as written by the health care provider for a patient who has undergone
135 an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to patients
136 who have undergone an organ transplant, the prescription for a particular immunosuppressive
137 drug as written by a health care provider meets the criteria of demonstrating to the Department
138 of Health a medical necessity for dispensing the prescribed immunosuppressive drug.
139 (d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the
140 state Medicaid drug program may not require the use of step therapy for immunosuppressive

141 drugs without the written or oral consent of the health care provider and the patient.
142 (e) The department may include a sedative hypnotic on a preferred drug list in
143 accordance with Subsection (2)(f).
144 (f) The department shall grant a prior authorization for a sedative hypnotic that is not
145 on the preferred drug list under Subsection (2)(e), if the health care provider has documentation
146 related to one of the following conditions for the Medicaid client:
147 (i) a trial and failure of at least one preferred agent in the drug class, including the
148 name of the preferred drug that was tried, the length of therapy, and the reason for the
149 discontinuation;
150 (ii) detailed evidence of a potential drug interaction between current medication and
151 the preferred drug;
152 (iii) detailed evidence of a condition or contraindication that prevents the use of the
153 preferred drug;
154 (iv) objective clinical evidence that a patient is at high risk of adverse events due to a
155 therapeutic interchange with a preferred drug;
156 (v) the patient is a new or previous Medicaid client with an existing diagnosis
157 previously stabilized with a nonpreferred drug; or
158 (vi) other valid reasons as determined by the department.
159 (g) A prior authorization granted under Subsection (2)(f) is valid for one year from the
160 date the department grants the prior authorization and shall be renewed in accordance with
161 Subsection (2)(f).
162 (3) (a) For purposes of this Subsection (3), "psychotropic drug" means the following
163 classes of drugs:
164 (i) atypical anti-psychotic;
165 (ii) anti-depressant;
166 (iii) anti-convulsant/mood stabilizer;
167 (iv) anti-anxiety; and
168 (v) attention deficit hyperactivity disorder stimulant.

169 (b) The department shall develop a preferred drug list for psychotropic drugs. Except
170 as provided in Subsection (3)(d), a preferred drug list for psychotropic drugs developed under
171 this section shall allow a health care provider to override the preferred drug list by writing
172 "dispense as written" on the prescription for the psychotropic drug. A health care provider may
173 not override Section 58-17b-606 by writing "dispense as written" on a prescription.
174 (c) The department, and a Medicaid accountable care organization that is responsible
175 for providing behavioral health, shall:
176 (i) establish a system to:
177 (A) track health care provider prescribing patterns for psychotropic drugs;
178 (B) educate health care providers who are not complying with the preferred drug list;
179 and
180 (C) implement peer to peer education for health care providers whose prescribing
181 practices continue to not comply with the preferred drug list; and
182 (ii) determine whether health care provider compliance with the preferred drug list is at
183 least:
184 (A) 55% of prescriptions by July 1, 2017;
185 (B) 65% of prescriptions by July 1, 2018; and
186 (C) 75% of prescriptions by July 1, 2019.
187 (d) Beginning October 1, 2019, the department shall eliminate the dispense as written
188 override for the preferred drug list, and shall implement a prior authorization system for
189 psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has
190 not realized annual savings from implementing the preferred drug list for psychotropic drugs of
191 at least $750,000 General Fund savings.
192 (e) The department shall report to the Health and Human Services Interim Committee
193 and the Social Services Appropriations Subcommittee before November 30, 2016, and before
194 each November 30 thereafter regarding compliance with and savings from implementation of
195 this Subsection (3).
196 [~~(3)~~] (4) The department shall report to the Health and Human Services Interim

197 Committee and to the Social Services Appropriations Subcommittee [~~prior to~~] <u>before</u>
198 November 1, 2013, regarding the savings to the Medicaid program resulting from the use of the
199 preferred drug list permitted by Subsection (1).
200 Section 2. Section **26-18-18** is amended to read:
201 **26-18-18. Optional Medicaid expansion.**
202 (1) For purposes of this section [~~PPACA is as~~]<u>, "PPACA" means the same as that term</u>
203 <u>is</u> defined in Section 31A-1-301.
204 (2) The department and the governor shall not expand the state's Medicaid program to
205 the optional population under PPACA unless:
206 [~~(a) the Health Reform Task Force has completed a thorough analysis of a statewide~~
207 ~~charity care system;~~]
208 [~~(b) the department and its contractors have:~~]
209 [~~(i) completed a thorough analysis of the impact to the state of expanding the state's~~
210 ~~Medicaid program to optional populations under PPACA; and~~]
211 [~~(ii) made the analysis conducted under Subsection (2)(b)(i) available to the public;~~]
212 [~~(c)~~] <u>(a)</u> the governor or the governor's designee has reported the intention to expand
213 the state Medicaid program under PPACA to the Legislature in compliance with the legislative
214 review process in Sections 63N-11-106 and 26-18-3; and
215 [~~(d)~~] <u>(b)</u> notwithstanding Subsection 63J-5-103(2), the governor submits the request
216 for expansion of the Medicaid program for optional populations to the Legislature under the
217 high impact federal funds request process required by Section 63J-5-204, Legislative review
218 and approval of certain federal funds request.
219 <u>(3) The department shall request approval from the Centers for Medicare and Medicaid</u>
220 <u>Services within the United States Department of Health and Human Services for waivers from</u>
221 <u>federal statutory and regulatory law necessary to implement the health coverage improvement</u>
222 <u>program under Section 26-18-411. The health coverage improvement program under Section</u>
223 <u>26-18-411 is not Medicaid expansion for purposes of this section.</u>
224 Section 3. Section **26-18-411** is enacted to read:

225 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
226 **-- Expansion of eligibility for adults with dependent children.**
227 (1) For purposes of this section:
228 (a) "Adult in the expansion population" means an individual who:
229 (i) is described in 42 U.S.C. Sec. 1396a(10)(A)(i)(VIII); and
230 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
231 individual.
232 (b) "CMS" means the Centers for Medicare and Medicaid Services within the United
233 States Department of Health and Human Services.
234 (c) "Federal poverty level" means the poverty guidelines established by the Secretary of
235 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).
236 (d) "Homeless":
237 (i) means an individual who is chronically homeless, as determined by the department;
238 and
239 (ii) includes someone who was chronically homeless and is currently living in
240 supported housing for the chronically homeless.
241 (e) "Income eligibility ceiling" means the percent of federal poverty level:
242 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
243 Chapter 1, Budgetary Procedures Act; and
244 (ii) under which an individual may qualify for Medicaid coverage in accordance with
245 this section.
246 (2) (a) No later than July 1, 2016, the division shall submit to CMS a request for
247 waivers, or an amendment of existing waivers, from federal statutory and regulatory law
248 necessary for the state to implement the health coverage improvement program in the Medicaid
249 program in accordance with this section.
250 (b) An adult in the expansion population is eligible for Medicaid if the adult meets the
251 income eligibility and other criteria established under Subsection (3).
252 (c) An adult who qualifies under Subsection (3) shall receive Medicaid coverage:

253 (i) through:

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

255 accountable care organizations or the state's Medicaid accountable care organization delivery

256 system, where implemented; and

257 (B) except as provided in Subsection (2)(c)(ii), for behavioral health, through the

258 counties in accordance with Sections 17-43-201 and 17-43-301;

259 (ii) that integrates behavioral health services and physical health services with

260 Medicaid accountable care organizations in select geographic areas of the state that choose an

261 integrated model; and

262 (iii) that permits temporary residential treatment for substance abuse in a short term,

263 non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that

264 provides rehabilitation services that are medically necessary and in accordance with an

265 individualized treatment plan.

266 (d) Medicaid accountable care organizations and counties that elect to integrate care

267 under Subsection (2)(c)(ii) shall collaborate on enrollment, engagement of patients, and

268 coordination of services.

269 (3) (a) An individual is eligible for the health coverage improvement program under

270 Subsection (2)(b) if:

271 (i) at the time of enrollment, the individual's annual income is below the income

272 eligibility ceiling established by the state under Subsection (1)(e); and

273 (ii) the individual meets the eligibility criteria established by the department under

274 Subsection (3)(b).

275 (b) Based on available funding and approval from CMS, the department shall select the

276 criteria for an individual to qualify for the Medicaid program under Subsection (3)(a)(ii), based

277 on the following priority:

278 (i) a chronically homeless individual;

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

280 (A) involved in the justice system through probation, parole, or court ordered

281 treatment; and
282 (B) in need of substance abuse treatment or mental health treatment, as determined by
283 the department; or
284 (iii) if funding is available, an individual in need of substance abuse treatment or
285 mental health treatment, as determined by the department.
286 (c) An individual who qualifies for Medicaid coverage under Subsections (3)(a) and (b)
287 may remain on the Medicaid program for a 12-month certification period as defined by the
288 department. Eligibility changes made by the department under Subsection (1)(e) or (3)(b) shall
289 not apply to an individual during the 12-month certification period.
290 (4) The state may request a modification of the income eligibility ceiling and other
291 eligibility criteria under Subsection (3) each fiscal year based on enrollment in the health
292 coverage improvement program, projected enrollment, costs to the state, and the state budget.
293 (5) On or before September 30, 2017, and on or before September 30 each year
294 thereafter, the department shall report to the Legislature's Health and Human Services Interim
295 Committee and to the Legislature's Executive Appropriations Committee:
296 (a) the number of individuals who enrolled in Medicaid under Subsection (3);
297 (b) the state cost of providing Medicaid to individuals enrolled under Subsection (3);
298 and
299 (c) recommendations for adjusting the income eligibility ceiling under Subsection (4),
300 and other eligibility criteria under Subsection (3), for the upcoming fiscal year.
301 (6) In addition to the waiver under Subsection (2), beginning July 1, 2016, the
302 department shall amend the state Medicaid plan:
303 (a) for an individual with a dependent child, to increase the income eligibility ceiling to
304 a percent of the federal poverty level designated by the department, based on appropriations for
305 the program; and
306 (b) to allow temporary residential treatment for substance abuse, for the traditional
307 Medicaid population, in a short term, non-institutional, 24-hour facility, without a bed capacity
308 limit that provides rehabilitation services that are medically necessary and in accordance with

309 an individualized treatment plan, as approved by CMS and as long as the county makes the
310 required match under Section 17-43-201.
311 (7) The current Medicaid program and the health coverage improvement program,
312 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
313 enrollment for an individual who is released from custody and was eligible for or enrolled in
314 Medicaid before incarceration.
315 (8) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
316 provide matching funds to the state for the cost of providing Medicaid services to newly
317 enrolled individuals who qualify for Medicaid coverage under the health coverage
318 improvement program under Subsection (3).
319 (9) The department shall:
320 (a) study, in consultation with health care providers, employers, uninsured families,
321 and community stakeholders:
322 (i) options to maximize use of employer sponsored coverage for current Medicaid
323 enrollees; and
324 (ii) strategies to increase participation of currently Medicaid eligible, and uninsured,
325 children; and
326 (b) report the findings of the study to the Legislature's Health Reform Task Force
327 before November 30, 2016.
328 Section 4. Section **26-36b-101** is enacted to read:
329 **CHAPTER 36b. INPATIENT HOSPITAL ASSESSMENT ACT**
330 **Part 1. General Provisions**
331 **26-36b-101. Title.**
332 This chapter is known as "Inpatient Hospital Assessment Act."
333 Section 5. Section **26-36b-102** is enacted to read:
334 **26-36b-102. Application.**
335 (1) Other than for the imposition of the assessment described in this chapter, nothing in
336 this chapter shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious,

337 or educational health care provider under:
338 (a) Section 501(c), as amended, of the Internal Revenue Code;
339 (b) other applicable federal law;
340 (c) any state law;
341 (d) any ad valorem property taxes;
342 (e) any sales or use taxes; or
343 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed, by
344 the state or any political subdivision, county, municipality, district, authority, or any agency or
345 department thereof.
346 (2) All assessments paid under this chapter may be included as an allowable cost of a
347 hospital for purposes of any applicable Medicaid reimbursement formula.
348 (3) This chapter does not authorize a political subdivision of the state to:
349 (a) license a hospital for revenue;
350 (b) impose a tax or assessment upon a hospital; or
351 (c) impose a tax or assessment measured by the income or earnings of a hospital.
352 Section 6. Section **26-36b-103** is enacted to read:
353 **26-36b-103. Definitions.**
354 As used in this chapter:
355 (1) "Assessment" means the inpatient hospital assessment established by this chapter.
356 (2) "CMS" means the same as that term is defined in Section 26-18-411.
357 (3) "Discharges" means the number of total hospital discharges reported on:
358 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost
359 report for the applicable assessment year; or
360 (b) a similar report adopted by the department by administrative rule, if the report
361 under Subsection (3)(a) is no longer available.
362 (4) "Division" means the Division of Health Care Financing within the department.
363 (5) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of
364 hospitals.

365 (6) "Non-state government hospital":
366 (a) means a hospital owned by a non-state government entity; and
367 (b) does not include:
368 (i) the Utah State Hospital; or
369 (ii) a hospital owned by the federal government, including the Veterans Administration
370 Hospital.
371 (7) "Private hospital":
372 (a) means:
373 (i) a privately owned general acute hospital operating in the state as defined in Section
374 26-21-2; and
375 (ii) a privately owned specialty hospital operating in the state, which shall include a
376 privately owned hospital whose inpatient admissions are predominantly:
377 (A) rehabilitation;
378 (B) psychiatric;
379 (C) chemical dependency; or
380 (D) long-term acute care services; and
381 (b) does not include a residential care or treatment facility as defined in Section
382 62A-2-101.
383 (8) "State teaching hospital" means a state owned teaching hospital that is part of an
384 institution of higher education.
385 Section 7. Section **26-36b-201** is enacted to read:
386 **Part 2. Assessment and Collection**
387 **26-36b-201. Assessment.**
388 (1) An assessment is imposed on each private hospital:
389 (a) beginning upon the later of CMS approval of:
390 (i) the health coverage improvement program waiver under Section 26-18-411; and
391 (ii) the assessment under this chapter;
392 (b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and

393 (c) in accordance with Section 26-36b-202.
394 (2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and
395 payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental
396 payments under Section 26-36b-210 have been paid.
397 (3) The first quarterly payment shall not be due until at least three months after the
398 effective date of the coverage provided through the health coverage improvement program
399 waiver under Section 26-18-411.
400 Section 8. Section **26-36b-202** is enacted to read:
401 **26-36b-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**
402 (1) The collecting agent for the assessment imposed under Section 26-36b-201 is the
403 department. The department is vested with the administration and enforcement of this chapter,
404 including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah
405 Administrative Rulemaking Act, necessary to:
406 (a) implement and enforce the provisions of this chapter;
407 (b) audit records of a facility that:
408 (i) is subject to the assessment imposed by this chapter; and
409 (ii) does not file a Medicare cost report; and
410 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
411 Medicare cost report.
412 (2) The department shall:
413 (a) administer the assessment in this part separate from the assessment in Chapter 36a,
414 Hospital Provider Assessment Act; and
415 (b) deposit assessments collected under this chapter into the Medicaid Expansion Fund
416 created by Section 26-36b-208.
417 Section 9. Section **26-36b-203** is enacted to read:
418 **26-36b-203. Quarterly notice.**
419 Quarterly assessments imposed by this chapter shall be paid to the division within 15
420 business days after the original invoice date that appears on the invoice issued by the division.

421 The department may, by rule, extend the time for paying the assessment.
422 Section 10. Section **26-36b-204** is enacted to read:
423 **26-36b-204. Hospital financing of health coverage improvement program**
424 **Medicaid waiver -- Hospital share.**
425 (1) For purposes of this section, "hospital share":
426 (a) means 45% of the state's net cost of:
427 (i) the health coverage improvement program Medicaid waiver under Section
428 26-18-411;
429 (ii) Medicaid coverage for individuals with dependent children up to the federal
430 poverty level designated under Section 26-18-411; and
431 (iii) the UPL gap, as that term is defined in Section 26-36b-210;
432 (b) for the hospital share of the additional coverage under Section 26-18-411, is capped
433 at no more than $13,600,000 annually, consisting of:
434 (i) an $11,900,000 cap on the hospital's share for the programs specified in Subsections
435 (1)(a)(i) and (ii); and
436 (ii) a $1,700,000 cap for the program specified in Subsection (1)(a)(iii);
437 (c) for the cap specified in Subsection (1)(b), shall be prorated in any year in which the
438 programs specified in Subsection (1)(a) are not in effect for the full fiscal year; and
439 (d) if the Medicaid program expands in a manner that is greater than the expansion
440 described in Section 26-18-411, is capped at 33% of the state's share of the cost of the
441 expansion that is in addition to the program described in Section 26-18-411.
442 (2) The assessment for the private hospital share under Subsection (1) shall be:
443 (a) 69% of the portion of the hospital share specified in Subsections (1)(a)(i) and (ii);
444 and
445 (b) 100% of the portion of the hospital share specified in Subsection (1)(a)(iii).
446 (3) (a) The department shall, on or before October 15, 2017, and on or before October
447 15 of each year thereafter, produce a report that calculates the state's net cost of the programs
448 described in Subsections (1)(a)(i) and (ii).

449 (b) If the assessment collected in the previous fiscal year is above or below the private
450 hospital's share of the state's net cost as specified in Subsection (2), for the previous fiscal year,
451 the underpayment or overpayment of the assessment by the private hospitals shall be applied to
452 the fiscal year in which the report was issued.
453 (4) A Medicaid accountable care organization shall, on or before October 15 of each
454 year, report to the department the following data from the prior state fiscal year:
455 (a) for the traditional Medicaid population, for each private hospital, state teaching
456 hospital, and non-state government hospital provider:
457 (i) hospital inpatient payments;
458 (ii) hospital inpatient discharges;
459 (iii) hospital inpatient days; and
460 (iv) hospital outpatient payments; and
461 (b) for the Medicaid population newly eligible under Subsection 26-18-411, for each
462 private hospital, state teaching hospital, and non-state government hospital provider:
463 (i) hospital inpatient payments;
464 (ii) hospital inpatient discharges;
465 (iii) hospital inpatient days; and
466 (iv) hospital outpatient payments.
467 Section 11. Section **26-36b-205** is enacted to read:
468 **26-36b-205. Calculation of assessment.**
469 (1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a
470 quarterly basis for each private hospital in an amount calculated at a uniform assessment rate
471 for each hospital discharge, in accordance with this section.
472 (b) A private teaching hospital with more than 425 beds and 60 residents shall pay an
473 assessment rate 2.50 times the uniform rate established under Subsection (1)(c).
474 (c) The uniform assessment rate shall be determined using the total number of hospital
475 discharges for assessed private hospitals, the percentages in Subsection 26-36b-204(2), and rule
476 adopted by the department.

477 (d) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
478 all assessed private hospitals.
479 (2) (a) For each state fiscal year, discharges shall be determined using the data from
480 each hospital's Medicare cost report contained in the Centers for Medicare and Medicaid
481 Services' Healthcare Cost Report Information System file. The hospital's discharge data will be
482 derived as follows:
483 (i) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year
484 ending between July 1, 2013, and June 30, 2014; and
485 (ii) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
486 fiscal year that ended in the state fiscal year two years before the assessment fiscal year.
487 (b) If a hospital's fiscal year Medicare cost report is not contained in the Centers for
488 Medicare and Medicaid Services' Healthcare Cost Report Information System file:
489 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
490 applicable to the assessment year; and
491 (ii) the division shall determine the hospital's discharges.
492 (c) If a hospital is not certified by the Medicare program and is not required to file a
493 Medicare cost report:
494 (i) the hospital shall submit to the division the hospital's applicable fiscal year
495 discharges with supporting documentation;
496 (ii) the division shall determine the hospital's discharges from the information
497 submitted under Subsection (2)(c)(i); and
498 (iii) the failure to submit discharge information shall result in an audit of the hospital's
499 records and a penalty equal to 5% of the calculated assessment.
500 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
501 owns more than one hospital in the state:
502 (a) the assessment for each hospital shall be separately calculated by the department;
503 and
504 (b) each separate hospital shall pay the assessment imposed by this chapter.

505 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the
506 same Medicaid provider number:
507 (a) the department shall calculate the assessment in the aggregate for the hospitals
508 using the same Medicaid provider number; and
509 (b) the hospitals may pay the assessment in the aggregate.
510 Section 12. Section **26-36b-206** is enacted to read:
511 **26-36b-206. State teaching hospital and non-state government hospital mandatory**
512 **intergovernmental transfer.**
513 (1) A state teaching hospital and a non-state government hospital shall make an
514 intergovernmental transfer to the Medicaid Expansion Fund created in Section 26-36b-208, in
515 accordance with this section.
516 (2) The intergovernmental transfer shall be paid beginning on the later of CMS
517 approval of:
518 (a) the health improvement program waiver under Section 26-18-411;
519 (b) the assessment for private hospitals in this chapter; and
520 (c) the intergovernmental transfer in this section.
521 (3) The intergovernmental transfer shall be paid in an amount divided as follows:
522 (a) the state teaching hospital is responsible for:
523 (i) 30% of the portion of the hospital share specified in Subsections
524 26-36b-204(1)(a)(i) and (ii); and
525 (ii) 0% of the hospital share specified in Subsection 26-36b-204(1)(a)(iii); and
526 (b) non-state government hospitals are responsible for:
527 (i) 1% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a)(i)
528 and (ii); and
529 (ii) 0% of the hospital share specified in Subsection 26-36b-204(1)(a)(iii).
530 (4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
531 Administrative Rulemaking Act, designate the method of calculating the percentages
532 designated in Subsection (3) and the schedule for the intergovernmental transfers.

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

534 **26-36b-207. Penalties and interest.**

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

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

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

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

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

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

550 (B) any unpaid penalty assessment.

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

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

555 **26-36b-208. Medicaid Expansion Fund.**

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

558 (2) The fund consists of:

559 (a) assessments collected under this chapter;

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

561 (c) savings attributable to the health coverage improvement program under Section
562 26-18-411 as determined by the department;
563 (d) savings attributable to the inclusion of psychotropic drugs on the preferred drug list
564 under Subsection 26-18-2.4(3) as determined by the department;
565 (e) savings attributable to the services provided by the Public Employees' Health Plan
566 under Subsection 49-20-401(1)(u);
567 (f) gifts, grants, donations, or any other conveyance of money that may be made to the
568 fund from private sources; and
569 (g) additional amounts as appropriated by the Legislature.
570 (3) (a) The fund shall earn interest.
571 (b) All interest earned on fund money shall be deposited into the fund.
572 (4) (a) A state agency administering the provisions of this chapter may use money from
573 the fund to pay the costs of the health coverage improvement Medicaid waiver under Section
574 26-18-411, and the outpatient UPL supplemental payments under Section 26-36b-210, not
575 otherwise paid for with federal funds or other revenue sources, except that no funds described
576 in Subsection (2)(b) may be used to pay the cost of outpatient UPL supplemental payments.
577 (b) Money in the fund may not be used for any other purpose.
578 Section 15. Section **26-36b-209** is enacted to read:
579 **26-36b-209. Hospital reimbursement.**
580 The department shall, to the extent allowed by law, include in a contract with a
581 Medicaid accountable care organization a requirement that the accountable care organization
582 reimburse hospitals in the accountable care organization's provider network, no less than the
583 Medicaid fee-for-service rate. Nothing in this section prohibits a Medicaid accountable care
584 organization from paying a rate that exceeds Medicaid fee-for-service rates.
585 Section 16. Section **26-36b-210** is enacted to read:
586 **26-36b-210. Outpatient upper payment limit supplemental payments.**
587 (1) For purposes of this section, "UPL gap" means the difference between the private
588 hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments,

589 as determined in accordance with 42 C.F.R. 447.321.
590 (2) Beginning on the effective date of the assessment imposed under this chapter, and
591 for each fiscal year thereafter, the department shall implement an outpatient upper payment
592 limit program for private hospitals that shall supplement the reimbursement to private hospitals
593 in accordance with Subsection (3).
594 (3) The supplemental payment to Utah private hospitals under Subsection (2) shall:
595 (a) not exceed the positive UPL gap; and
596 (b) be allocated based on the Medicaid state plan.
597 (4) The outpatient data used to calculate the UPL gap under Subsection (1) shall be the
598 same outpatient data used to allocate the payments under Subsection (3).
599 (5) The supplemental payments to private hospitals under Subsection (2) shall be
600 payable for outpatient hospital services provided on or after the later of:
601 (a) July 1, 2016;
602 (b) the effective date of the Medicaid state plan amendment necessary to implement the
603 payments under this section; or
604 (c) the effective date of the coverage provided through the health coverage
605 improvement program waiver under Section 26-18-411.
606 Section 17. Section **26-36b-211** is enacted to read:
607 **26-36b-211. Repeal of assessment.**
608 (1) The repeal of the assessment imposed by this chapter shall occur upon the
609 certification by the executive director of the department that the sooner of the following has
610 occurred:
611 (a) the effective date of any action by Congress that would disqualify the assessment
612 imposed by this chapter from counting toward state Medicaid funds available to be used to
613 determine the federal financial participation;
614 (b) the effective date of any decision, enactment, or other determination by the
615 Legislature or by any court, officer, department, or agency of the state, or of the federal
616 government, that has the effect of:

617 (i) disqualifying the assessment from counting toward state Medicaid funds available
618 to be used to determine federal financial participation for Medicaid matching funds; or
619 (ii) creating for any reason a failure of the state to use the assessments for the Medicaid
620 program as described in this chapter;
621 (c) the effective date of a change that reduces the aggregate hospital inpatient and
622 outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for
623 July 1, 2015; and
624 (d) the sunset of this chapter in accordance with Section 63I-1-226.
625 (2) If the assessment is repealed under Subsection (1), money in the fund that was
626 derived from assessments imposed by this chapter, before the determination made under
627 Subsection (1), shall be disbursed under Section 26-36b-207 to the extent federal matching is
628 not reduced due to the impermissibility of the assessments. Any funds remaining in the special
629 revenue fund shall be refunded to the hospitals in proportion to the amount paid by each
630 hospital.
631 Section 18. Section **49-20-401** is amended to read:
632 **49-20-401. Program -- Powers and duties.**
633 (1) The program shall:
634 (a) act as a self-insurer of employee benefit plans and administer those plans;
635 (b) enter into contracts with private insurers or carriers to underwrite employee benefit
636 plans as considered appropriate by the program;
637 (c) indemnify employee benefit plans or purchase commercial reinsurance as
638 considered appropriate by the program;
639 (d) provide descriptions of all employee benefit plans under this chapter in cooperation
640 with covered employers;
641 (e) process claims for all employee benefit plans under this chapter or enter into
642 contracts, after competitive bids are taken, with other benefit administrators to provide for the
643 administration of the claims process;
644 (f) obtain an annual actuarial review of all health and dental benefit plans and a

645 periodic review of all other employee benefit plans;
646 (g) consult with the covered employers to evaluate employee benefit plans and develop
647 recommendations for benefit changes;
648 (h) annually submit a budget and audited financial statements to the governor and
649 Legislature which includes total projected benefit costs and administrative costs;
650 (i) maintain reserves sufficient to liquidate the unrevealed claims liability and other
651 liabilities of the employee benefit plans as certified by the program's consulting actuary;
652 (j) submit, in advance, its recommended benefit adjustments for state employees to:
653 (i) the Legislature; and
654 (ii) the executive director of the state Department of Human Resource Management;
655 (k) determine benefits and rates, upon approval of the board, for multiemployer risk
656 pools, retiree coverage, and conversion coverage;
657 (l) determine benefits and rates based on the total estimated costs and the employee
658 premium share established by the Legislature, upon approval of the board, for state employees;
659 (m) administer benefits and rates, upon ratification of the board, for single employer
660 risk pools;
661 (n) request proposals for provider networks or health and dental benefit plans
662 administered by third party carriers at least once every three years for the purposes of:
663 (i) stimulating competition for the benefit of covered individuals;
664 (ii) establishing better geographical distribution of medical care services; and
665 (iii) providing coverage for both active and retired covered individuals;
666 (o) offer proposals which meet the criteria specified in a request for proposals and
667 accepted by the program to active and retired state covered individuals and which may be
668 offered to active and retired covered individuals of other covered employers at the option of the
669 covered employer;
670 (p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for
671 the Department of Health if the program provides program benefits to children enrolled in the
672 Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's

673 Health Insurance Act;
674 (q) establish rules and procedures governing the admission of political subdivisions or
675 educational institutions and their employees to the program;
676 (r) contract directly with medical providers to provide services for covered individuals;
677 (s) take additional actions necessary or appropriate to carry out the purposes of this
678 chapter; [~~and~~]
679 (t) (i) require state employees and their dependents to participate in the electronic
680 exchange of clinical health records in accordance with Section 26-1-37 unless the enrollee opts
681 out of participation; and
682 (ii) prior to enrolling the state employee, each time the state employee logs onto the
683 program's website, and each time the enrollee receives written enrollment information from the
684 program, provide notice to the enrollee of the enrollee's participation in the electronic exchange
685 of clinical health records and the option to opt out of participation at any time[~~.~~]; and
686 (u) provide services for drugs or medical devices at the request of a procurement unit,
687 as that term is defined in Section 63G-6a-104, that administers benefits to program recipients
688 who are not covered by Title 26, Utah Health Code.
689 (2) (a) Funds budgeted and expended shall accrue from rates paid by the covered
690 employers and covered individuals.
691 (b) Administrative costs shall be approved by the board and reported to the governor
692 and the Legislature.
693 (3) The Department of Human Resource Management shall include the benefit
694 adjustments described in Subsection (1)(j) in the total compensation plan recommended to the
695 governor required under Subsection 67-19-12(5)(a).
696 Section 19. Section **63I-1-226** is amended to read:
697 **63I-1-226. Repeal dates, Title 26.**
698 (1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July
699 1, 2025.
700 (2) Section 26-10-11 is repealed July 1, 2020.

701 (3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed
702 July 1, 2018.
703 (4) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.
704 (5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2016.
705 (6) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, 2021.
706 [(6)] (7) Section 26-38-2.5 is repealed July 1, 2017.
707 [(7)] (8) Section 26-38-2.6 is repealed July 1, 2017.
708 [(8)] (9) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.
709 Section 20. **Appropriation.**
710 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for
711 the fiscal year beginning July 1, 2016, and ending June 30, 2017, the following sums of money
712 are appropriated from resources not otherwise appropriated, or reduced from amounts
713 previously appropriated, out of the funds or amounts indicated. These sums of money are in
714 addition to amounts previously appropriated for fiscal year 2017.

715	To Fund and Account Transfers -- State Endowment Fund		
716	From General Fund Restricted -- Tobacco Settlement Account		($1,488,700)
717	Schedule of Programs:		
718	State Endowment Fund	($1,488,700)	
719	To Department of Health -- Medicaid Optional Services		
720	From General Fund		($1,488,700)
721	From General Fund Restricted -- Tobacco Settlement Account		$1,488,700
722	To Department of Human Services -- Substance Abuse and Mental Health		
723	From General Fund		($819,800)
724	From General Fund, one-time		$419,800
725	From Federal Funds		$819,800
726	From Federal Funds, one-time		($419,800)
727	To Department of Human Services -- Child and Family Services		
728	From General Fund		($200,000)

729 Schedule of Programs:
730 Out-of-home Care ($200,000)
731 To Department of Health -- Medicaid Expansion Fund
732 From General Fund $2,508,500
733 From General Fund, one-time ($419,800)
734 Schedule of Programs:
735 Medicaid Expansion Fund $2,088,700