

1                                   **PRIMARY CARE NETWORK AMENDMENTS**

2   2018 GENERAL SESSION

3   STATE OF UTAH

4   **Chief Sponsor: Steve Eliason**

5   Senate Sponsor: Brian Zehnder

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7 **LONG TITLE**

8 **General Description:**

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

13 **Highlighted Provisions:**

14                   This bill:

- 15                   ▶ directs the Department of Health to apply for a new waiver or an amendment to an  
16 existing waiver to implement the Primary Care Network enhancement waiver  
17 program described in this bill; and
- 18                   ▶ amends the Inpatient Hospital Assessment Act to pay for the cost of the  
19 enhancement waiver program.

20 **Money Appropriated in this Bill:**

21                   None

22 **Other Special Clauses:**

23                   This bill provides coordination clauses.

24 **Utah Code Sections Affected:**

25 AMENDS:

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

27                   **26-36b-102**, as enacted by Laws of Utah 2016, Chapter 279

28                   **26-36b-103**, as enacted by Laws of Utah 2016, Chapter 279

29                   **26-36b-201**, as enacted by Laws of Utah 2016, Chapter 279

- 30            **26-36b-202**, as enacted by Laws of Utah 2016, Chapter 279
- 31            **26-36b-203**, as enacted by Laws of Utah 2016, Chapter 279
- 32            **26-36b-204**, as enacted by Laws of Utah 2016, Chapter 279
- 33            **26-36b-205**, as enacted by Laws of Utah 2016, Chapter 279
- 34            **26-36b-206**, as enacted by Laws of Utah 2016, Chapter 279
- 35            **26-36b-207**, as enacted by Laws of Utah 2016, Chapter 279
- 36            **26-36b-208**, as enacted by Laws of Utah 2016, Chapter 279
- 37            **26-36b-209**, as enacted by Laws of Utah 2016, Chapter 279
- 38            **26-36b-210**, as enacted by Laws of Utah 2016, Chapter 279
- 39            **26-36b-211**, as enacted by Laws of Utah 2016, Chapter 279
- 40            **63I-1-226**, as last amended by Laws of Utah 2017, Chapters 177 and 443

41 ENACTS:

42            **26-18-415**, Utah Code Annotated 1953

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

- 44            **26-18-415**, Utah Code Annotated 1953
- 45            **26-36b-103**, as enacted by Laws of Utah 2016, Chapter 279
- 46            **26-36b-201**, as enacted by Laws of Utah 2016, Chapter 279
- 47            **26-36b-204**, as enacted by Laws of Utah 2016, Chapter 279
- 48            **26-36b-206**, as enacted by Laws of Utah 2016, Chapter 279
- 49            **26-36b-208**, as enacted by Laws of Utah 2016, Chapter 279
- 50            **26-36b-209**, as enacted by Laws of Utah 2016, Chapter 279
- 51            **26-36b-211**, as enacted by Laws of Utah 2016, Chapter 279



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

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

55            **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**  
56 **-- Expansion of eligibility for adults with dependent children.**

57            (1) For purposes of this section:

58 (a) "Adult in the expansion population" means an individual who:  
59 (i) is described in 42 U.S.C. Sec. 1396a(10)(A)(i)(VIII); and  
60 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy  
61 individual.

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

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

66 ~~[(e)]~~ (d) "Federal poverty level" means the poverty guidelines established by the  
67 Secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec.  
68 9909(2).

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

71 ~~[(d)]~~ (f) "Homeless":  
72 (i) means an individual who is chronically homeless, as determined by the department;  
73 and  
74 (ii) includes someone who was chronically homeless and is currently living in  
75 supported housing for the chronically homeless.

76 ~~[(e)]~~ (g) "Income eligibility ceiling" means the percent of federal poverty level:  
77 (i) established by the state in an appropriations act adopted pursuant to Title 63J,  
78 Chapter 1, Budgetary Procedures Act; and  
79 (ii) under which an individual may qualify for Medicaid coverage in accordance with  
80 this section.

81 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to  
82 allow temporary residential treatment for substance abuse, for the traditional Medicaid  
83 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that  
84 provides rehabilitation services that are medically necessary and in accordance with an  
85 individualized treatment plan, as approved by CMS and as long as the county makes the

86 required match under Section 17-43-201.

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

91 [~~2~~](a) ~~No later than~~

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

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

98 [~~e~~](b) An adult who qualifies under Subsection [~~3~~](6) shall receive Medicaid  
99 coverage:

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

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

105 [~~i~~](iii) that integrates behavioral health services and physical health services with  
106 Medicaid accountable care organizations in select geographic areas of the state that choose an  
107 integrated model; and

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

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

114 patients, and coordination of services.

115 ~~[(3)]~~ (6) (a) An individual is eligible for the health coverage improvement program  
116 under Subsection ~~[(2)(b)]~~ (5) if:

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

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

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

124 (i) a chronically homeless individual;

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

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

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

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

132 (c) An individual who qualifies for Medicaid coverage under Subsections ~~[(3)]~~ (6)(a)  
133 and (b) may remain on the Medicaid program for a 12-month certification period as defined by  
134 the department. Eligibility changes made by the department under Subsection (1)~~[(e)]~~(g) or  
135 ~~[(3)]~~ (6)(b) shall not apply to an individual during the 12-month certification period.

136 ~~[(4)]~~ (7) The state may request a modification of the income eligibility ceiling and  
137 other eligibility criteria under Subsection ~~[(3)]~~ (6) each fiscal year based on enrollment in the  
138 health coverage improvement program, projected enrollment, costs to the state, and the state  
139 budget.

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

141 (8) Before September 30 of each year ~~[thereafter]~~, the department shall report to the

142 [Legislature's] Health and Human Services Interim Committee and to the [Legislature's]  
143 Executive Appropriations Committee:

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

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

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

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

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

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

159 ~~[(7)]~~ (9) The current Medicaid program and the health coverage improvement program,  
160 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid  
161 enrollment for an individual who is released from custody and was eligible for or enrolled in  
162 Medicaid before incarceration.

163 ~~[(8)]~~ (10) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have  
164 to provide matching funds to the state for the cost of providing Medicaid services to newly  
165 enrolled individuals who qualify for Medicaid coverage under the health coverage  
166 improvement program under Subsection ~~[(3)]~~ (6).

167 ~~[(9) The department shall:]~~

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

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

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

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

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

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

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

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

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

186 (e) shall work with CMS to maintain any waiver for the health coverage improvement  
187 program while the health coverage improvement program is suspended under Subsection  
188 (11)(c).

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

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

195 **26-18-415. Primary Care Network enhancement waiver program.**

196 (1) As used in this section:

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

198 States Department of Health and Human Services.

199 (b) "Enhancement waiver program" means the Primary Care Network enhancement  
200 waiver program described in this section.

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

203 (d) "Health coverage improvement program" means the same as that term is defined in  
204 Section [26-18-411](#).

205 (e) "Income eligibility ceiling" means the percentage of federal poverty level:

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

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

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

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

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

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

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

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

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

223 (b) diagnostic testing and procedures;

224 (c) medical specialty care;

225 (d) inpatient hospital services;



226 (e) outpatient hospital services;  
227 (f) outpatient behavioral health care, including outpatient substance abuse care; and  
228 (g) for an individual who qualifies for the health coverage improvement program, as  
229 approved by CMS, temporary residential treatment for substance abuse in a short term,  
230 non-institutional, 24-hour facility, without a bed capacity limit, that provides rehabilitation  
231 services that are medically necessary and in accordance with an individualized treatment plan.

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

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

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

238 (c) the individual meets the eligibility criteria established by the department under  
239 Subsection (6).

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

243 (i) adults in the expansion population, as defined in Section [26-18-411](#), who qualify for  
244 the health coverage improvement program;

245 (ii) adults with dependent children who qualify for the health coverage improvement  
246 program under Subsection [26-18-411\(3\)](#);

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

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

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

253 (c) The department may only use appropriations from the Medicaid Expansion Fund

254 created in Section 26-36b-208 to fund the state portion of the enhancement waiver program.

255 (d) The money deposited into the Medicaid Expansion Fund under Subsections  
256 26-36b-208(g) and (h) may only be used to pay the cost of enrolling individuals who qualify for  
257 the enhancement waiver program under Subsections (6)(a)(iii) and (iv).

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

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

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

267 (10) If the department expands the state Medicaid program to the optional population,  
268 the department:

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

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

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

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

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

283 **26-36b-102. Application.**

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

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

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

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

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

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

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

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

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

298 (a) license a hospital for revenue;

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

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

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

302 **26-36b-103. Definitions.**

303 As used in this chapter:

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

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

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

309 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost

310 report for the applicable assessment year; or

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

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

314 (5) "Enhancement waiver program" means the program established by the Primary  
315 Care Network enhancement waiver program described in Section [26-18-415](#).

316 (6) "Health coverage improvement program" means the health coverage improvement  
317 program described in Section [26-18-411](#).

318 (7) "Hospital share" means the hospital share described in Section [26-36b-203](#).

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

322 ~~[(5)]~~ (9) "Medicare cost report" means CMS-2552-10, the cost report for electronic  
323 filing of hospitals.

324 ~~[(6)]~~ (10) (a) "Non-state government hospital"~~[(a)]~~ means a hospital owned by a  
325 non-state government entity~~[-and]~~.

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

327 (i) the Utah State Hospital; or

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

330 ~~[(7)]~~ (11) (a) "Private hospital"~~[(a)]~~ means:

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

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

335 (A) rehabilitation;

336 (B) psychiatric care;

337 (C) chemical dependency services; or

- 338 (D) long-term acute care services~~[-and]~~.
- 339 (b) "Private hospital" does not include a facility for residential [care or] treatment
- 340 [facility] as defined in Section 62A-2-101.
- 341 ~~[(8)]~~ (12) "State teaching hospital" means a state owned teaching hospital that is part of
- 342 an institution of higher education.
- 343 (13) "Upper payment limit gap" means the difference between the private hospital
- 344 outpatient upper payment limit and the private hospital Medicaid outpatient payments, as
- 345 determined in accordance with 42 C.F.R. Sec. 447.321.

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

347 **26-36b-201. Assessment.**

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

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

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

351 (ii) the assessment under this chapter;

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

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

354 (2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and

355 payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental

356 payments under Section 26-36b-210 have been paid.

357 (3) The first quarterly payment ~~[shall not be]~~ is not due until at least three months after

358 the earlier of the effective [date] dates of the coverage provided through:

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

360 (b) the enhancement waiver program.

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

362 **26-36b-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**

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

364 department.

365 (2) The department is vested with the administration and enforcement of this chapter,

366 [~~including the right to adopt administrative~~] and may make rules in accordance with Title 63G,  
 367 Chapter 3, Utah Administrative Rulemaking Act, necessary to:

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

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

371 (b) audit records of a facility that:

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

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

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

376 (2) The department shall:

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

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

381 Section 7. Section **26-36b-203** is amended to read:

382 **26-36b-203. Quarterly notice.**

383 (1) Quarterly assessments imposed by this chapter shall be paid to the division within  
 384 15 business days after the original invoice date that appears on the invoice issued by the  
 385 division.

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

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

388 **26-36b-204. Hospital financing of health coverage improvement program**

389 **Medicaid waiver -- Hospital share.**

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

391 (1) The hospital share is:

392 (a) 45% of the state's net cost of[~~-(i)~~] the health coverage improvement program

393 [~~Medicaid waiver under Section [26-18-411](#); (ii)~~], including Medicaid coverage for individuals

394 with dependent children up to the federal poverty level designated under Section [26-18-411](#);

395 [~~and~~]

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

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

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

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

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

401 of:

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

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

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

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

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

407 which the programs specified in [~~Subsection~~] Subsections (1)(a) and (c) are not in effect for the

408 full fiscal year[~~; and~~].

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

410 expansion described in Section [26-18-411](#)[~~;~~] and the enhancement described in Section

411 [26-18-415](#), the hospital share is capped at 33% of the state's share of the cost of the expansion

412 or enhancement that is in addition to the [~~program~~] programs described in Section [26-18-411](#) or

413 [26-18-415](#).

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

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

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

417 and (b); and

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

419 [~~(3)~~] (4) (a) The department shall, on or before October 15, 2017, and on or before

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

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

422 that year.

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

427 [~~(4)~~] (5) A Medicaid accountable care organization shall, on or before October 15 of  
428 each year, report to the department the following data from the prior state fiscal year for each  
429 private hospital, state teaching hospital, and non-state government hospital provider that the  
430 Medicaid accountable care organization contracts with:

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

- 433 (i) hospital inpatient payments;
- 434 (ii) hospital inpatient discharges;
- 435 (iii) hospital inpatient days; and
- 436 (iv) hospital outpatient payments; and

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

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

- 442 (i) hospital inpatient payments;
- 443 (ii) hospital inpatient discharges;
- 444 (iii) hospital inpatient days; and
- 445 (iv) hospital outpatient payments.

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

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



450 **26-36b-205. Calculation of assessment.**

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

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

456 (c) The division shall calculate the uniform assessment rate ~~[shall be determined using~~  
457 ~~the total number of hospital discharges for assessed private hospitals, the percentages in~~  
458 ~~Subsection 26-36b-204(2), and rule adopted by the department.]~~ described in Subsection (1)(a)  
459 by dividing the hospital share for assessed private hospitals, described in Subsection  
460 26-36b-204(1), by the sum of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

495            [(3)] (4) Except as provided in Subsection [(4)] (5), if a hospital is owned by an  
496 organization that owns more than one hospital in the state:

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

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

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

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

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

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

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

506           **26-36b-206. State teaching hospital and non-state government hospital**  
 507 **mandatory intergovernmental transfer.**

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

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

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

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

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

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

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

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

520 ~~26-36b-204(1)(a)[(i) and (ii)]~~ and (b); and

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

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

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

524 ~~and (ii)]~~ and (b); and

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

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

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

529 and

530           (b) the schedule for the intergovernmental transfers.

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

532           **26-36b-207. Penalties.**

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

534 intergovernmental transfer, or file a return as required under this chapter, within the time  
535 required by this chapter, shall pay penalties described in this section, in addition to the  
536 assessment or intergovernmental transfer~~[, and interest established by the department].~~

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

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

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

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

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

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

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

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

554 **26-36b-208. Medicaid Expansion Fund.**

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

557 (2) The fund consists of:

558 (a) assessments collected under this chapter;

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

560 (c) savings attributable to the health coverage improvement program [~~under Section~~  
561 ~~26-18-411~~] as determined by the department;

562 (d) savings attributable to the enhancement waiver program as determined by the  
 563 department;  
 564 ~~[(d)]~~ (e) savings attributable to the inclusion of psychotropic drugs on the preferred  
 565 drug list under Subsection 26-18-2.4(3) as determined by the department;  
 566 ~~[(e)]~~ (f) savings attributable to the services provided by the Public Employees' Health  
 567 Plan under Subsection 49-20-401(1)(u);  
 568 ~~[(f)]~~ (g) gifts, grants, donations, or any other conveyance of money that may be made to  
 569 the fund from private sources; ~~and~~  
 570 (h) interest earned on money in the fund; and  
 571 ~~[(g)]~~ (i) additional amounts as appropriated by the Legislature.  
 572 (3) (a) The fund shall earn interest.  
 573 (b) All interest earned on fund money shall be deposited into the fund.  
 574 (4) (a) A state agency administering the provisions of this chapter may use money from  
 575 the fund to pay the costs ~~[of], not otherwise paid for with federal funds or other revenue~~  
 576 sources, of:  
 577 (i) the health coverage improvement ~~[Medicaid waiver under Section 26-18-411, and]~~  
 578 program;  
 579 (ii) the enhancement waiver program; and  
 580 (iii) the outpatient ~~[UPE] upper payment limit~~ supplemental payments under Section  
 581 26-36b-210~~[, not otherwise paid for with federal funds or other revenue sources, except that~~  
 582 no].  
 583 (b) A state agency administering the provisions of this chapter may not use:  
 584 (i) funds described in Subsection (2)(b) ~~[may be used]~~ to pay the cost of private  
 585 outpatient ~~[UPE] upper payment limit~~ supplemental payments~~[-]; or~~  
 586 ~~[(b)]~~ (ii) ~~[Money] money~~ in the fund ~~[may not be used]~~ for any ~~[other]~~ purpose not  
 587 described in Subsection (4)(a).  
 588 Section 13. Section **26-36b-209** is amended to read:  
 589 **26-36b-209. Hospital reimbursement.**

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

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

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

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

603 **26-36b-210. Outpatient upper payment limit supplemental payments.**

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

607 ~~[(2)]~~ (1) Beginning on the effective date of the assessment imposed under this chapter,  
 608 and for each subsequent fiscal year ~~[thereafter]~~, the department shall implement an outpatient  
 609 upper payment limit program for private hospitals that shall supplement the reimbursement to  
 610 private hospitals in accordance with Subsection ~~[(3)]~~ (2).

611 ~~[(3)]~~ (2) The division shall ensure that supplemental payment to Utah private hospitals  
 612 under Subsection ~~[(2) shall]~~ (1):

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

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

615 ~~[(4)]~~ (3) The department shall use the same outpatient data ~~[used to calculate the UPL~~  
 616 ~~gap under Subsection (1) shall be the same outpatient data used]~~ to allocate the payments under  
 617 Subsection ~~[(3)]~~ (2) and to calculate the upper payment limit gap.

618 ~~[(5)]~~ (4) The supplemental payments to private hospitals under Subsection ~~[(2) shall~~  
 619 ~~be]~~ (1) are payable for outpatient hospital services provided on or after the later of:

620 (a) July 1, 2016;

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

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

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

626 **26-36b-211. Repeal of assessment.**

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

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

631 (a) the executive director certifies that:

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

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

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

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

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

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

645 (iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient

646 payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1,  
647 2015; ~~[and] or~~

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

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

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

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

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

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

665 (d) any money remaining in the Medicaid Expansion Fund after the disbursements  
666 described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of  
667 the fiscal year that the assessment is suspended.

668 Section 16. Section **63I-1-226** is amended to read:

669 **63I-1-226. Repeal dates, Title 26.**

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

671 (2) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July  
672 1, 2025.

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



- 674 (4) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.
- 675 (5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, 2019.
- 676 (6) Title 26, Chapter 36b, Inpatient Hospital Assessment Act, is repealed July 1, 2021.
- 677 [~~(7) Section 26-38-2.5 is repealed July 1, 2017.~~]
- 678 [~~(8) Section 26-38-2.6 is repealed July 1, 2017.~~]
- 679 [(9)] (7) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2021.

680 Section 17. **Coordinating H.B. 325 with H.B. 14 -- Superseding substantive and**  
681 **technical amendments.**

682 If this H.B. 325 and H.B. 14, Substance Abuse Treatment Facility Patient Brokering,  
683 both pass and become law, it is the intent of the Legislature that the amendments to Section  
684 26-36b-103 in this bill supersede the amendments to Section 26-36b-103 in H.B. 14, when the  
685 Office of Legislative Research and General Counsel prepares the Utah Code database for  
686 publication.

687 Section 18. **Coordinating H.B. 325 with H.B. 472 -- Substantive and technical**  
688 **amendments.**

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

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

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

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

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

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

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

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

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

708 (b) the enhancement waiver program; or

709 (c) the Medicaid waiver expansion.";

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

711 "26-36b-204. Hospital financing of health coverage improvement program

712 Medicaid waiver -- Hospital share.

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

714 (1) The hospital share is:

715 (a) 45% of the state's net cost of[:(i)] the health coverage improvement program

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

718 [and]

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

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

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

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

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

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

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

727 Subsections (1)(a)[(i) and (ii)] through (c); and

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

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

730 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in  
 731 which the programs specified in [Subsection] Subsections (1)(a) and (d) are not in effect for the  
 732 full fiscal year[; and].

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

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

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

738 (a) 69% of the portion of the hospital share for the programs specified in Subsections  
 739 (1)(a)~~[(i) and (ii)]~~ through (c); and

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

741 ~~[(3)]~~ (4) (a) The department shall, on or before October 15, 2017, and on or before  
 742 October 15 of each subsequent year [thereafter], produce a report that calculates the state's net  
 743 cost of each of the programs described in Subsections (1)(a)~~[(i) and (ii)]~~ through (c) that are in  
 744 effect for that year.

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

749 ~~[(4)]~~ (5) A Medicaid accountable care organization shall, on or before October 15 of  
 750 each year, report to the department the following data from the prior state fiscal year for each  
 751 private hospital, state teaching hospital, and non-state government hospital provider that the  
 752 Medicaid accountable care organization contracts with:

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

755 (i) hospital inpatient payments;

756 (ii) hospital inpatient discharges;

757 (iii) hospital inpatient days; and

758 (iv) hospital outpatient payments; and  
 759 ~~[(b) for the Medicaid population newly eligible under Subsection 26-18-411, for each~~  
 760 ~~private hospital, state teaching hospital, and non-state government hospital provider:]~~

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

- 764 (i) hospital inpatient payments;
- 765 (ii) hospital inpatient discharges;
- 766 (iii) hospital inpatient days; and
- 767 (iv) hospital outpatient payments.

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

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

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

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

775 (i) 30% of the portion of the hospital share specified in Subsections  
 776 26-36b-204(1)(a)[(i) and (ii)] through (c); and

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

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

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

781 (ii) 0% of the hospital share specified in Subsection 26-36b-204(1)[(a)(iii)](d).";

782 (5) modifying Section 26-36b-208 to read:

783 "26-36b-208. Medicaid Expansion Fund.

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

786 (2) The fund consists of:

787 (a) assessments collected under this chapter;

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

789 (c) savings attributable to the health coverage improvement program [~~under Section~~

790 ~~26-18-411~~] as determined by the department;

791 (d) savings attributable to the enhancement waiver program as determined by the

792 department;

793 (e) savings attributable to the Medicaid waiver expansion as determined by the

794 department;

795 [~~(f)~~] (f) savings attributable to the inclusion of psychotropic drugs on the preferred

796 drug list under Subsection 26-18-2.4(3) as determined by the department;

797 [~~(g)~~] (g) savings attributable to the services provided by the Public Employees' Health

798 Plan under Subsection 49-20-401(1)(u);

799 [~~(h)~~] (h) gifts, grants, donations, or any other conveyance of money that may be made to

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

801 (i) interest earned on money in the fund; and

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

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

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

805 (4) (a) A state agency administering the provisions of this chapter may use money from

806 the fund to pay the costs [~~of~~], not otherwise paid for with federal funds or other revenue

807 sources, of:

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

809 program;

810 (ii) the enhancement waiver program;

811 (iii) the Medicaid waiver expansion; and

812 (iv) the outpatient [~~UPE~~] upper payment limit supplemental payments under Section

813 26-36b-210[~~, not otherwise paid for with federal funds or other revenue sources, except that~~

814 no].

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

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

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

820 (6) modifying Section 26-36b-209 to read:

821 "**26-36b-209. Hospital reimbursement.**

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

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

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

835 (7) Section 26-36b-211 in this H.B. 325 supersedes Section 26-36b-211 in H.B. 472.

836 Section 19. **Coordinating H.B. 325 with S.B. 125 -- Superseding substantive and**  
837 **technical amendments.**

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

