

Part 4 Medicaid Waiver

26-18-402 Medicaid Restricted Account.

- (1) There is created a restricted account in the General Fund known as the Medicaid Restricted Account.
- (2)
 - (a) Except as provided in Subsection (3), the following shall be deposited into the Medicaid Restricted Account:
 - (i) any general funds appropriated to the department for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and which are not otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account;
 - (ii) any unused state funds that are associated with the Medicaid program, as defined in Section 26-18-2, from the Department of Workforce Services and the Department of Human Services; and
 - (iii) any penalties imposed and collected under:
 - (A) Section 17B-2a-818.5;
 - (B) Section 19-1-206;
 - (C) Section 63A-5-205;
 - (D) Section 63C-9-403;
 - (E) Section 72-6-107.5; or
 - (F) Section 79-2-404.
 - (b) The account shall earn interest and all interest earned shall be deposited into the account.
 - (c) The Legislature may appropriate money in the restricted account to fund programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.
- (3) For fiscal years 2008-09, 2009-10, 2010-11, 2011-12, and 2012-13 the following funds are nonlapsing:
 - (a) any general funds appropriated to the department for the state plan for medical assistance, or for the Division of Health Care Financing that are not expended by the department in the fiscal year in which the general funds were appropriated; and
 - (b) funds described in Subsection (2)(a)(ii).

Amended by Chapter 278, 2013 General Session

26-18-403 Medicaid waiver for independent foster care adolescents.

- (1) For purposes of this section, an "independent foster care adolescent" includes any individual who reached 18 years of age while in the custody of the Division of Child and Family Services, or the Department of Human Services if the Division of Child and Family Services was the primary case manager, or a federally recognized Indian tribe.
- (2) An independent foster care adolescent is eligible, when funds are available, for Medicaid coverage until the individual reaches 21 years of age.
- (3) Before July 1, 2006, the division shall submit a state Medicaid Plan amendment to the Center For Medicaid Services to provide medical coverage for independent foster care adolescents effective fiscal year 2006-07.

Enacted by Chapter 110, 2006 General Session

26-18-404 Home and community-based long-term care -- Room and board assistance.

If the department receives approval from the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services to replace the Medicaid program's current FlexCare program with a new program to provide long-term care services in home and community-based settings rather than institutions, the department shall assist in the payment of room and board costs for any person in the new program without sufficient income to fully pay those costs.

Enacted by Chapter 190, 2007 General Session

26-18-405 Waivers to maximize replacement of fee-for-service delivery model -- Cost of mandated program changes.

- (1) The department shall develop a waiver program in the Medicaid program to replace the fee-for-service delivery model with one or more risk-based delivery models.
- (2) The waiver program shall:
 - (a) restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the waiver program, maintain or improve recipient health status;
 - (b) restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to:
 - (i) maintain or improve their health status; and
 - (ii) use providers that deliver the most appropriate services at the lowest cost;
 - (c) identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that:
 - (i) pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter; and
 - (ii) reward providers for delivering services that make the most positive contribution to a recipient's health status;
 - (d) limit total annual per-patient-per-month expenditures for services delivered through fee-for-service arrangements to total annual per-patient-per-month expenditures for services delivered through risk-based arrangements covering similar recipient populations and services; and
 - (e) except as provided in Subsection (4), limit the rate of growth in per-patient-per-month General Fund expenditures for the program to the rate of growth in General Fund expenditures for all other programs, when the rate of growth in the General Fund expenditures for all other programs is greater than zero.
- (3) To the extent possible, the department shall operate the waiver program with the input of stakeholder groups representing those who will be affected by the waiver program.
- (4)
 - (a) For purposes of this Subsection (4), "mandated program change" shall be determined by the department in consultation with the Medicaid accountable care organizations, and may include a change to the state Medicaid program that is required by state or federal law, state or federal guidance, policy, or the state Medicaid plan.

- (b) A mandated program change shall be included in the base budget for the Medicaid program for the fiscal year in which the Medicaid program adopted the mandated program change.
- (c) The mandated program change is not subject to the limit on the rate of growth in per-patient-per-month General Fund expenditures for the program established in Subsection (2)(e), until the fiscal year following the fiscal year in which the Medicaid program adopted the mandated program change.

Amended by Chapter 168, 2016 General Session

Amended by Chapter 222, 2016 General Session

Amended by Chapter 394, 2016 General Session

26-18-405.5 Base budget appropriations for Medicaid accountable care organizations.

- (1) For purposes of this section:
 - (a) "ACOs" means accountable care organizations.
 - (b) "Base budget" means the same as that term is defined in legislative rule.
 - (c) "Current fiscal year PMPM" means per-member-per-month funding for Medicaid accountable care organizations under the Department of Health in the current fiscal year.
 - (d) "General Fund growth factor" means the amount determined by dividing the next fiscal year ongoing General Fund revenue estimate by current fiscal year ongoing appropriations from the General Fund.
 - (e) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal year ongoing General Fund revenue estimate identified by the Executive Appropriations Subcommittee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal Analyst in preparing budget recommendations.
 - (f) "Next fiscal year PMPM" means per-member-per-month funding for Medicaid accountable care organizations under the Department of Health for the next fiscal year.
- (2) If the General Fund growth factor is less than 100%, the next fiscal year base budget shall include an appropriation to the Department of Health for Medicaid ACOs in an amount necessary to ensure that next fiscal year PMPM equals current fiscal year PMPM multiplied by 100%.
- (3) If the General Fund growth factor is greater than or equal to 100%, but less than 102%, the next fiscal year base budget shall include an appropriation to the Department of Health for Medicaid ACOs in an amount necessary to ensure that next fiscal year PMPM equals current fiscal year PMPM multiplied by the General Fund growth factor.
- (4) If the General Fund growth factor is greater than or equal to 102%, the next fiscal year base budget shall include an appropriation to the Department of Health for Medicaid ACOs in an amount necessary to ensure that next fiscal year PMPM is greater than or equal to PMPM multiplied by 102% and less than or equal to current fiscal year PMPM multiplied by the General Fund growth factor.
- (5) In order for the department to estimate the impact of Subsections (2) through (4) prior to identification of the next fiscal year ongoing General Fund revenue estimate under Subsection (1)(e), the Governor's Office of Management and Budget shall, in cooperation with the Office of the Legislative Fiscal Analyst, develop an estimate of ongoing General Fund revenue for the next fiscal year and provide it to the department no later than September 1 of each year.

Enacted by Chapter 288, 2015 General Session

26-18-406 Medicaid waiver for community service pilot program.

- (1) For purposes of this section, "community service pilot program" is a program in which the department:
 - (a) identifies less than 100 Medicaid recipients who are capable of providing community services to others;
 - (b) exempts a Medicaid recipient who is not capable of providing community services from the requirements of the community service pilot program;
 - (c) identifies community services that the department will recognize for purposes of the pilot program; and
 - (d) requires an individual identified under Subsection (1)(a) who is receiving Medicaid services to perform a certain number of hours of community service as a condition of receiving Medicaid benefits.
- (2) The department shall develop a proposal to amend the state Medicaid plan to include a community service pilot program.
- (3) The department shall, by January 1, 2012, apply for a Medicaid waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement a community service pilot program within the state Medicaid plan.

Amended by Chapter 167, 2013 General Session

26-18-407 Medicaid waiver for autism spectrum disorder.

- (1) As used in this section:
 - (a) "Autism spectrum disorder" is as defined by the most recent edition of the Diagnostic and Statistical Manual on Mental Disorders or a recent edition of a professionally accepted diagnostic manual.
 - (b) "Program" means the autism spectrum disorder program created in Subsection (3).
 - (c) "Qualified child" means a child who is:
 - (i) at least two years of age but less than seven years of age; and
 - (ii) diagnosed with an autism spectrum disorder by a qualified professional.
- (2) The department shall apply for a Medicaid waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement, within the state Medicaid program, the program described in Subsection (3).
- (3) The department shall offer an autism spectrum disorder program that:
 - (a) as funding permits, provides treatment for autism spectrum disorders to qualified children; and
 - (b) accepts applications for the program during periods of open enrollment.
- (4) The department shall:
 - (a) convene a public process with the Department of Human Services to determine the benefits and services the program shall offer qualified children that considers, in addition to any other relevant factor:
 - (i) demonstrated effective treatments;
 - (ii) methods to engage family members in the treatment process; and
 - (iii) outreach to qualified children in rural and underserved areas of the state; and
 - (b) evaluate the ongoing results, cost, and effectiveness of the program.
- (5) The department shall annually report to the Legislature's Health and Human Services Interim Committee before each November 30 while the waiver is in effect regarding:
 - (a) the number of qualified children served under the waiver;
 - (b) success involving families in supporting treatment plans for autistic children;
 - (c) the cost of the program; and

(d) the results and effectiveness of the program.

Amended by Chapter 302, 2014 General Session

26-18-408 Incentives to appropriately use emergency department services.

- (1)
- (a) This section applies to the Medicaid program and to the Utah Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.
 - (b) For purposes of this section:
 - (i) "Accountable care organization" means a Medicaid or Children's Health Insurance Program administrator that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through an accountable care plan.
 - (ii) "Accountable care plan" means a risk based delivery service model authorized by Section 26-18-405 and administered by an accountable care organization.
 - (iii) "Nonemergent care":
 - (A) means use of the emergency department to receive health care that is nonemergent as defined by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act and the Emergency Medical Treatment and Active Labor Act; and
 - (B) does not mean the medical services provided to a recipient required by the Emergency Medical Treatment and Active Labor Act, including services to conduct a medical screening examination to determine if the recipient has an emergent or nonemergent condition.
 - (iv) "Professional compensation" means payment made for services rendered to a Medicaid recipient by an individual licensed to provide health care services.
 - (v) "Super-utilizer" means a Medicaid recipient who has been identified by the recipient's accountable care organization as a person who uses the emergency department excessively, as defined by the accountable care organization.
- (2)
- (a) An accountable care organization may, in accordance with Subsections (2)(b) and (c):
 - (i) audit emergency department services provided to a recipient enrolled in the accountable care plan to determine if nonemergent care was provided to the recipient; and
 - (ii) establish differential payment for emergent and nonemergent care provided in an emergency department.
 - (b)
 - (i) The differential payments under Subsection (2)(a)(ii) do not apply to professional compensation for services rendered in an emergency department.
 - (ii) Except in cases of suspected fraud, waste, and abuse, an accountable care organization's audit of payment under Subsection (2)(a)(i) is limited to the 18-month period of time after the date on which the medical services were provided to the recipient. If fraud, waste, or abuse is alleged, the accountable care organization's audit of payment under Subsection (2)(a)(i) is limited to three years after the date on which the medical services were provided to the recipient.
 - (c) The audits and differential payments under Subsections (2)(a) and (b) apply to services provided to a recipient on or after July 1, 2015.
- (3) An accountable care organization shall:
- (a) use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all of the recipients enrolled in the accountable care plan;

- (b) provide viable alternatives for increasing primary care provider reimbursement rates to incentivize after hours primary care access for recipients; and
 - (c) report to the department on how the accountable care organization complied with this Subsection (3).
- (4) The department shall:
- (a) through administrative rule adopted by the department, develop quality measurements that evaluate an accountable care organization's delivery of:
 - (i) appropriate emergency department services to recipients enrolled in the accountable care plan;
 - (ii) expanded primary care and urgent care for recipients enrolled in the accountable care plan, with consideration of the accountable care organization's:
 - (A) delivery of primary care, urgent care, and after hours care through means other than the emergency department;
 - (B) recipient access to primary care providers and community health centers including evening and weekend access; and
 - (C) other innovations for expanding access to primary care; and
 - (iii) quality of care for the accountable care plan members;
 - (b) compare the quality measures developed under Subsection (4)(a) for each accountable care organization and share the data and quality measures developed under Subsection (4)(a) with the Health Data Committee created in Chapter 33a, Utah Health Data Authority Act;
 - (c) apply for a Medicaid waiver and a Children's Health Insurance Program waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services, to:
 - (i) allow the program to charge recipients who are enrolled in an accountable care plan a higher copayment for emergency department services; and
 - (ii) develop, by administrative rule, an algorithm to determine assignment of new, unassigned recipients to specific accountable care plans based on the plan's performance in relation to the quality measures developed pursuant to Subsection (4)(a); and
 - (d) before July 1, 2015, convene representatives from the accountable care organizations, pre-paid mental health plans, an organization representing hospitals, an organization representing physicians, and a county mental health and substance abuse authority to discuss alternatives to emergency department care, including:
 - (i) creating increased access to primary care services;
 - (ii) alternative care settings for super-utilizers and individuals with behavioral health or substance abuse issues;
 - (iii) primary care medical and health homes that can be created and supported through enhanced federal match rates, a state plan amendment for integrated care models, or other Medicaid waivers;
 - (iv) case management programs that can:
 - (A) schedule prompt visits with primary care providers within 72 to 96 hours of an emergency department visit;
 - (B) help super-utilizers with behavioral health or substance abuse issues to obtain care in appropriate care settings; and
 - (C) assist with transportation to primary care visits if transportation is a barrier to appropriate care for the recipient; and
 - (v) sharing of medical records between health care providers and emergency departments for Medicaid recipients.

- (5) The Health Data Committee may publish data in accordance with Chapter 33a, Utah Health Data Authority Act, which compares the quality measures for the accountable care plans.
- (6) The department shall report to the Legislature's Health and Human Services Interim Committee on or before October 1, 2016, regarding implementation of this section.

Amended by Chapter 246, 2015 General Session

26-18-409 Long-term care insurance partnership.

- (1) As used in this section:
 - (a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec. 7702B(b).
 - (b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec. 1396p(b)(1)(C)(iii).
 - (c) "State plan amendment" means an amendment to the state Medicaid plan drafted by the department in compliance with this section.
- (2) No later than July 1, 2014, the department shall seek federal approval of a state plan amendment that creates a qualified long-term care insurance partnership.
- (3) The department may make rules to comply with federal laws and regulations relating to qualified long-term care insurance partnerships and qualified long-term care insurance contracts.

Enacted by Chapter 174, 2014 General Session

26-18-410 Medicaid waiver for children with disabilities and complex medical needs.

- (1) As used in this section:
 - (a) "Complex medical condition" means a physical condition of an individual that:
 - (i) results in severe functional limitations for the individual; and
 - (ii) is likely to:
 - (A) last at least 12 months; or
 - (B) result in death.
 - (b) "Program" means the program for children with complex medical conditions created in Subsection (3).
 - (c) "Qualified child" means a child who:
 - (i) is less than 19 years old;
 - (ii) is diagnosed with a complex medical condition;
 - (iii) has a condition that meets the definition of disability in 42 U.S.C. Sec. 12102; and
 - (iv) meets the additional eligibility criteria determined by the department under Subsection (4).
- (2) The department shall apply, no later than June 30, 2015, for a Medicaid home and community-based waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement, within the state Medicaid program, the program described in Subsection (3).
- (3) If the waiver described in Subsection (2) is approved, the department shall offer a program that:
 - (a) as funding permits, provides treatment for qualified children; and
 - (b) accepts applications for the program during periods of open enrollment.
- (4) The department shall:
 - (a) seek to prioritize, in the waiver described in Subsection (2), entrance into the program based on the:
 - (i) complexity of a qualified child's medical condition; and
 - (ii) financial needs of a qualified child and the qualified child's family;

- (b) convene a public process to determine:
 - (i) the benefits and services to offer a qualified child under the program; and
 - (ii) additional eligibility criteria for a qualified child; and
- (c) evaluate, on an ongoing basis, the cost and effectiveness of the program.
- (5) The department shall annually report, beginning in 2016, to the Legislature's Health and Human Services Interim Committee before November 30 while the waiver is in effect regarding:
 - (a) the number of qualified children served under the program;
 - (b) the cost of the program; and
 - (c) the effectiveness of the program.

Enacted by Chapter 209, 2015 General Session

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

- (1) For purposes of this section:
 - (a) "Adult in the expansion population" means an individual who:
 - (i) is described in 42 U.S.C. Sec. 1396a(10)(A)(i)(VIII); and
 - (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy individual.
 - (b) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.
 - (c) "Federal poverty level" means the poverty guidelines established by the Secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).
 - (d) "Homeless":
 - (i) means an individual who is chronically homeless, as determined by the department; and
 - (ii) includes someone who was chronically homeless and is currently living in supported housing for the chronically homeless.
 - (e) "Income eligibility ceiling" means the percent of federal poverty level:
 - (i) established by the state in an appropriations act adopted pursuant to Title 63J, Chapter 1, Budgetary Procedures Act; and
 - (ii) under which an individual may qualify for Medicaid coverage in accordance with this section.
- (2)
 - (a) No later than July 1, 2016, the division shall submit to CMS a request for waivers, or an amendment of existing waivers, from federal statutory and regulatory law necessary for the state to implement the health coverage improvement program in the Medicaid program in accordance with this section.
 - (b) An adult in the expansion population is eligible for Medicaid if the adult meets the income eligibility and other criteria established under Subsection (3).
 - (c) An adult who qualifies under Subsection (3) shall receive Medicaid coverage:
 - (i) through:
 - (A) the traditional fee for service Medicaid model in counties without Medicaid accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented; and
 - (B) except as provided in Subsection (2)(c)(ii), for behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;
 - (ii) that integrates behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model; and

- (iii) that permits temporary residential treatment for substance abuse in a short term, non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan.
 - (d) Medicaid accountable care organizations and counties that elect to integrate care under Subsection (2)(c)(ii) shall collaborate on enrollment, engagement of patients, and coordination of services.
- (3)
- (a) An individual is eligible for the health coverage improvement program under Subsection (2)(b) if:
 - (i) at the time of enrollment, the individual's annual income is below the income eligibility ceiling established by the state under Subsection (1)(e); and
 - (ii) the individual meets the eligibility criteria established by the department under Subsection (3)(b).
 - (b) Based on available funding and approval from CMS, the department shall select the criteria for an individual to qualify for the Medicaid program under Subsection (3)(a)(ii), based on the following priority:
 - (i) a chronically homeless individual;
 - (ii) if funding is available, an individual:
 - (A) involved in the justice system through probation, parole, or court ordered treatment; and
 - (B) in need of substance abuse treatment or mental health treatment, as determined by the department; or
 - (iii) if funding is available, an individual in need of substance abuse treatment or mental health treatment, as determined by the department.
 - (c) An individual who qualifies for Medicaid coverage under Subsections (3)(a) and (b) may remain on the Medicaid program for a 12-month certification period as defined by the department. Eligibility changes made by the department under Subsection (1)(e) or (3)(b) shall not apply to an individual during the 12-month certification period.
- (4) The state may request a modification of the income eligibility ceiling and other eligibility criteria under Subsection (3) each fiscal year based on enrollment in the health coverage improvement program, projected enrollment, costs to the state, and the state budget.
- (5) On or before September 30, 2017, and on or before September 30 each year thereafter, the department shall report to the Legislature's Health and Human Services Interim Committee and to the Legislature's Executive Appropriations Committee:
- (a) the number of individuals who enrolled in Medicaid under Subsection (3);
 - (b) the state cost of providing Medicaid to individuals enrolled under Subsection (3); and
 - (c) recommendations for adjusting the income eligibility ceiling under Subsection (4), and other eligibility criteria under Subsection (3), for the upcoming fiscal year.
- (6) In addition to the waiver under Subsection (2), beginning July 1, 2016, the department shall amend the state Medicaid plan:
- (a) for an individual with a dependent child, to increase the income eligibility ceiling to a percent of the federal poverty level designated by the department, based on appropriations for the program; and
 - (b) to allow temporary residential treatment for substance abuse, for the traditional Medicaid population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan, as approved by CMS and as long as the county makes the required match under Section 17-43-201.

- (7) The current Medicaid program and the health coverage improvement program, when implemented, shall coordinate with a state prison or county jail to expedite Medicaid enrollment for an individual who is released from custody and was eligible for or enrolled in Medicaid before incarceration.
- (8) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to provide matching funds to the state for the cost of providing Medicaid services to newly enrolled individuals who qualify for Medicaid coverage under the health coverage improvement program under Subsection (3).
- (9) The department shall:
 - (a) study, in consultation with health care providers, employers, uninsured families, and community stakeholders:
 - (i) options to maximize use of employer sponsored coverage for current Medicaid enrollees; and
 - (ii) strategies to increase participation of currently Medicaid eligible, and uninsured, children; and
 - (b) report the findings of the study to the Legislature's Health Reform Task Force before November 30, 2016.

Enacted by Chapter 279, 2016 General Session

26-18-413 Medicaid waiver for delivery of adult dental services.

- (1) No later than June 30, 2016, the department shall ask the United States Secretary of Health and Human Services to grant waivers from federal statutory and regulatory law necessary for the Medicaid program to provide dental services in the manner described in Subsection (2).
- (2)
 - (a) To the extent funded, services shall be provided to only blind or disabled individuals, as defined in 42 U.S.C. Sec. 1382c(a)(1), who are 18 years of age or older and eligible for the program.
 - (b) To the extent possible, services within Salt Lake County shall be provided through the University of Utah School of Dentistry.
 - (c) Each fiscal year, the University of Utah School of Dentistry shall transfer money to the program in an amount equal to the program's non-federal share of the cost of providing services under this section through the school during the fiscal year.
 - (d) During each general session of the Legislature, the department shall report to the Social Services Appropriations Subcommittee whether the University of Utah School of Dentistry will have sufficient funds to make the transfer required by Subsection (2)(c) for the current fiscal year.
 - (e) Where possible, services not provided by the University of Utah School of Dentistry shall be provided through managed care or other risk sharing arrangements.
 - (f) Subject to appropriations by the Legislature, and as determined by the department, the scope, amount, duration, and frequency of services may be limited.
- (3) The reporting requirements of Section 26-18-3 apply to the waivers requested under Subsection (1).
- (4) If the waivers requested under Subsection (1) are granted, the Medicaid program shall begin providing dental services in the manner described in Subsection (2) no later than May 1, 2017.
- (5) If the federal share of the cost of providing dental services under this section will be less than 65% during any portion of the next fiscal year, the Medicaid program shall cease providing dental services under this section indefinitely no later than the end of the current fiscal year.

Enacted by Chapter 284, 2016 General Session