

Part 1 Medical Assistance Programs

26-18-1 Short title.

This chapter shall be known and may be cited as the "Medical Assistance Act."

Enacted by Chapter 126, 1981 General Session

26-18-2 Definitions.

As used in this chapter:

- (1) "Applicant" means any person who requests assistance under the medical programs of the state.
- (2) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.
- (3) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.
- (4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.
- (5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.
- (6)
 - (a) "Passenger vehicle" means a self-propelled, two-axle vehicle intended primarily for operation on highways and used by an applicant or recipient to meet basic transportation needs and has a fair market value below 40% of the applicable amount of the federal luxury passenger automobile tax established in 26 U.S.C. Sec. 4001 and adjusted annually for inflation.
 - (b) "Passenger vehicle" does not include:
 - (i) a commercial vehicle, as defined in Section 41-1a-102;
 - (ii) an off-highway vehicle, as defined in Section 41-1a-102; or
 - (iii) a motor home, as defined in Section 13-14-102.
- (7) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

Amended by Chapter 1, 2000 General Session

26-18-2.1 Division -- Creation.

There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

Enacted by Chapter 21, 1988 General Session

26-18-2.2 Director -- Appointment -- Responsibilities.

The director of the division shall be appointed by the governor, after consultation with the executive director, with the advice and consent of the Senate. The director of the division may employ other employees as necessary to implement the provisions of this chapter, and shall:

- (1) administer the responsibilities of the division as set forth in this chapter;
- (2) prepare and administer the division's budget; and
- (3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

Amended by Chapter 267, 2011 General Session

26-18-2.3 Division responsibilities -- Emphasis -- Periodic assessment.

- (1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:
 - (a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;
 - (b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and
 - (c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.
- (2) The division shall implement and utilize cost-containment methods, where possible, which may include:
 - (a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;
 - (b) preadmission certification of nonemergency admissions;
 - (c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;
 - (d) second surgical opinions;
 - (e) procedures for encouraging the use of outpatient services;
 - (f) consistent with Sections 26-18-2.4 and 58-17b-606, a Medicaid drug program;
 - (g) coordination of benefits; and
 - (h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.
- (3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.
- (4) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery.
- (5) The department shall, by December 31 of each year, report to the Social Services Appropriations Subcommittee regarding:
 - (a) measures taken under this section to increase:
 - (i) efficiencies within the program; and
 - (ii) cost avoidance and cost recovery efforts in the program; and
 - (b) results of program integrity efforts under Subsection (4).

Amended by Chapter 242, 2012 General Session

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

- (1) A Medicaid drug program developed by the department under Subsection 26-18-2.3(2)(f):
 - (a) shall, notwithstanding Subsection 26-18-2.3(1)(b), be based on clinical and cost-related factors which include medical necessity as determined by a provider in accordance with administrative rules established by the Drug Utilization Review Board;
 - (b) may include therapeutic categories of drugs that may be exempted from the drug program;
 - (c) may include placing some drugs, except the drugs described in Subsection (2), on a preferred drug list:
 - (i) to the extent determined appropriate by the department; and
 - (ii) in the manner described in Subsection (3) for psychotropic drugs;
 - (d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and except as provided in Subsection (3), shall immediately implement the prior authorization requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:
 - (i) on the preferred drug list on the date that this act takes effect; or
 - (ii) added to the preferred drug list after this act takes effect; and
 - (e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior authorization requirements established under Subsections (1)(c) and (d) which shall permit a health care provider or the health care provider's agent to obtain a prior authorization override of the preferred drug list through the department's pharmacy prior authorization review process, and which shall:
 - (i) provide either telephone or fax approval or denial of the request within 24 hours of the receipt of a request that is submitted during normal business hours of Monday through Friday from 8 a.m. to 5 p.m.;
 - (ii) provide for the dispensing of a limited supply of a requested drug as determined appropriate by the department in an emergency situation, if the request for an override is received outside of the department's normal business hours; and
 - (iii) require the health care provider to provide the department with documentation of the medical need for the preferred drug list override in accordance with criteria established by the department in consultation with the Pharmacy and Therapeutics Committee.
- (2)
 - (a) For purposes of this Subsection (2):
 - (i) "Immunosuppressive drug":
 - (A) means a drug that is used in immunosuppressive therapy to inhibit or prevent activity of the immune system to aid the body in preventing the rejection of transplanted organs and tissue; and
 - (B) does not include drugs used for the treatment of autoimmune disease or diseases that are most likely of autoimmune origin.
 - (ii) "Stabilized" means a health care provider has documented in the patient's medical chart that a patient has achieved a stable or steadfast medical state within the past 90 days using a particular psychotropic drug.
 - (b) A preferred drug list developed under the provisions of this section may not include an immunosuppressive drug.
 - (c) The state Medicaid program shall reimburse for a prescription for an immunosuppressive drug as written by the health care provider for a patient who has undergone an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to patients who have undergone an organ transplant, the prescription for a particular immunosuppressive drug as written by

a health care provider meets the criteria of demonstrating to the Department of Health a medical necessity for dispensing the prescribed immunosuppressive drug.

- (d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the state Medicaid drug program may not require the use of step therapy for immunosuppressive drugs without the written or oral consent of the health care provider and the patient.
 - (e) The department may include a sedative hypnotic on a preferred drug list in accordance with Subsection (2)(f).
 - (f) The department shall grant a prior authorization for a sedative hypnotic that is not on the preferred drug list under Subsection (2)(e), if the health care provider has documentation related to one of the following conditions for the Medicaid client:
 - (i) a trial and failure of at least one preferred agent in the drug class, including the name of the preferred drug that was tried, the length of therapy, and the reason for the discontinuation;
 - (ii) detailed evidence of a potential drug interaction between current medication and the preferred drug;
 - (iii) detailed evidence of a condition or contraindication that prevents the use of the preferred drug;
 - (iv) objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange with a preferred drug;
 - (v) the patient is a new or previous Medicaid client with an existing diagnosis previously stabilized with a nonpreferred drug; or
 - (vi) other valid reasons as determined by the department.
 - (g) A prior authorization granted under Subsection (2)(f) is valid for one year from the date the department grants the prior authorization and shall be renewed in accordance with Subsection (2)(f).
- (3)
- (a) For purposes of this Subsection (3), "psychotropic drug" means the following classes of drugs:
 - (i) atypical anti-psychotic;
 - (ii) anti-depressant;
 - (iii) anti-convulsant/mood stabilizer;
 - (iv) anti-anxiety; and
 - (v) attention deficit hyperactivity disorder stimulant.
 - (b) The department shall develop a preferred drug list for psychotropic drugs. Except as provided in Subsection (3)(d), a preferred drug list for psychotropic drugs developed under this section shall allow a health care provider to override the preferred drug list by writing "dispense as written" on the prescription for the psychotropic drug. A health care provider may not override Section 58-17b-606 by writing "dispense as written" on a prescription.
 - (c) The department, and a Medicaid accountable care organization that is responsible for providing behavioral health, shall:
 - (i) establish a system to:
 - (A) track health care provider prescribing patterns for psychotropic drugs;
 - (B) educate health care providers who are not complying with the preferred drug list; and
 - (C) implement peer to peer education for health care providers whose prescribing practices continue to not comply with the preferred drug list; and
 - (ii) determine whether health care provider compliance with the preferred drug list is at least:
 - (A) 55% of prescriptions by July 1, 2017;
 - (B) 65% of prescriptions by July 1, 2018; and
 - (C) 75% of prescriptions by July 1, 2019.

- (d) Beginning October 1, 2019, the department shall eliminate the dispense as written override for the preferred drug list, and shall implement a prior authorization system for psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has not realized annual savings from implementing the preferred drug list for psychotropic drugs of at least \$750,000 General Fund savings.
- (e) The department shall report to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee before November 30, 2016, and before each November 30 thereafter regarding compliance with and savings from implementation of this Subsection (3).

Amended by Chapter 168, 2016 General Session

Amended by Chapter 279, 2016 General Session

26-18-2.5 Simplified enrollment and renewal process for Medicaid and other state medical programs -- Financial institutions.

- (1) The department may:
 - (a) apply for grants and accept donations to:
 - (i) make technology system improvements necessary to implement a simplified enrollment and renewal process for the Medicaid program, Utah Premium Partnership, and Primary Care Network Demonstration Project programs; and
 - (ii) conduct an actuarial analysis of the implementation of a basic health care plan in the state in 2014 to provide coverage options to individuals from 133% to 200% of the federal poverty level; and
 - (b) if funding is available:
 - (i) implement the simplified enrollment and renewal process in accordance with this section; and
 - (ii) conduct the actuarial analysis described in Subsection (1)(a)(ii).
- (2) The simplified enrollment and renewal process established in this section shall, in accordance with Section 59-1-403, provide an eligibility worker a process in which the eligibility worker:
 - (a) verifies the applicant's or enrollee's identity;
 - (b) gets consent to obtain the applicant's adjusted gross income from the State Tax Commission from:
 - (i) the applicant or enrollee, if the applicant or enrollee filed a single tax return; or
 - (ii) both parties to a joint return, if the applicant filed a joint tax return; and
 - (c) obtains from the State Tax Commission, the adjusted gross income of the applicant or enrollee.
- (3)
 - (a) The department may enter into an agreement with a financial institution doing business in the state to develop and operate a data match system to identify an applicant's or enrollee's assets that:
 - (i) uses automated data exchanges to the maximum extent feasible; and
 - (ii) requires a financial institution each month to provide the name, record address, Social Security number, other taxpayer identification number, or other identifying information for each applicant or enrollee who maintains an account at the financial institution.
 - (b) The department may pay a reasonable fee to a financial institution for compliance with this Subsection (3), as provided in Section 7-1-1006.
 - (c) A financial institution may not be liable under any federal or state law to any person for any disclosure of information or action taken in good faith under this Subsection (3).

- (d) The department may disclose a financial record obtained from a financial institution under this section only for the purpose of, and to the extent necessary in, verifying eligibility as provided in this section and Section 26-40-105.

Amended by Chapter 279, 2012 General Session

26-18-2.6 Dental benefits.

- (1)
 - (a) Except as provided in Subsection (8), the division shall establish a competitive bid process to bid out Medicaid dental benefits under this chapter.
 - (b) The division may bid out the Medicaid dental benefits separately from other program benefits.
- (2) The division shall use the following criteria to evaluate dental bids:
 - (a) ability to manage dental expenses;
 - (b) proven ability to handle dental insurance;
 - (c) efficiency of claim paying procedures;
 - (d) provider contracting, discounts, and adequacy of network; and
 - (e) other criteria established by the department.
- (3) The division shall request bids for the program's benefits:
 - (a) in 2011; and
 - (b) at least once every five years thereafter.
- (4) The division's contract with dental plans for the program's benefits shall include risk sharing provisions in which the dental plan must accept 100% of the risk for any difference between the division's premium payments per client and actual dental expenditures.
- (5) The division may not award contracts to:
 - (a) more than three responsive bidders under this section; or
 - (b) an insurer that does not have a current license in the state.
- (6)
 - (a) The division may cancel the request for proposals if:
 - (i) there are no responsive bidders; or
 - (ii) the division determines that accepting the bids would increase the program's costs.
 - (b) If the division cancels the request for proposals under Subsection (6)(a), the division shall report to the Health and Human Services Interim Committee regarding the reasons for the decision.
- (7) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.
- (8)
 - (a) The division may:
 - (i) establish a dental health care delivery system and payment reform pilot program for Medicaid dental benefits to increase access to cost effective and quality dental health care by increasing the number of dentists available for Medicaid dental services; and
 - (ii) target specific Medicaid populations or geographic areas in the state.
 - (b) The pilot program shall establish compensation models for dentists and dental hygienists that:
 - (i) increase access to quality, cost effective dental care; and
 - (ii) use funds from the Division of Family Health and Preparedness that are available to reimburse dentists for educational loans in exchange for the dentist agreeing to serve Medicaid and under-served populations.
 - (c) The division may amend the state plan and apply to the Secretary of Health and Human Services for waivers or pilot programs if necessary to establish the new dental care delivery and payment reform model. The division shall evaluate the pilot program's effect on the cost

of dental care and access to dental care for the targeted Medicaid populations. The division shall report to the Legislature's Health and Human Services Interim Committee by November 30th of each year that the pilot project is in effect.

Amended by Chapter 278, 2013 General Session

Amended by Chapter 278, 2013 General Session

26-18-3 Administration of Medicaid program by department -- Reporting to the Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility standards -- Internal audits -- Health opportunity accounts.

- (1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.
- (2)
 - (a) The department shall implement the Medicaid program through administrative rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the requirements of Title XIX, and applicable federal regulations.
 - (b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules necessary to implement the program:
 - (i) the standards used by the department for determining eligibility for Medicaid services;
 - (ii) the services and benefits to be covered by the Medicaid program;
 - (iii) reimbursement methodologies for providers under the Medicaid program; and
 - (iv) a requirement that:
 - (A) a person receiving Medicaid services shall participate in the electronic exchange of clinical health records established in accordance with Section 26-1-37 unless the individual opts out of participation;
 - (B) prior to enrollment in the electronic exchange of clinical health records the enrollee shall receive notice of enrollment in the electronic exchange of clinical health records and the right to opt out of participation at any time; and
 - (C) beginning July 1, 2012, when the program sends enrollment or renewal information to the enrollee and when the enrollee logs onto the program's website, the enrollee shall receive notice of the right to opt out of the electronic exchange of clinical health records.
- (3)
 - (a) The department shall, in accordance with Subsection (3)(b), report to the Social Services Appropriations Subcommittee when the department:
 - (i) implements a change in the Medicaid State Plan;
 - (ii) initiates a new Medicaid waiver;
 - (iii) initiates an amendment to an existing Medicaid waiver;
 - (iv) applies for an extension of an application for a waiver or an existing Medicaid waiver; or
 - (v) initiates a rate change that requires public notice under state or federal law.
 - (b) The report required by Subsection (3)(a) shall:
 - (i) be submitted to the Social Services Appropriations Subcommittee prior to the department implementing the proposed change; and
 - (ii) include:
 - (A) a description of the department's current practice or policy that the department is proposing to change;
 - (B) an explanation of why the department is proposing the change;

- (C) the proposed change in services or reimbursement, including a description of the effect of the change;
- (D) the effect of an increase or decrease in services or benefits on individuals and families;
- (E) the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and
- (F) the fiscal impact of the proposed change, including:
 - (I) the effect of the proposed change on current or future appropriations from the Legislature to the department;
 - (II) the effect the proposed change may have on federal matching dollars received by the state Medicaid program;
 - (III) any cost shifting or cost savings within the department's budget that may result from the proposed change; and
 - (IV) identification of the funds that will be used for the proposed change, including any transfer of funds within the department's budget.
- (4) Any rules adopted by the department under Subsection (2) are subject to review and reauthorization by the Legislature in accordance with Section 63G-3-502.
- (5) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including:
 - (a) the determination of the eligibility of individuals for the program;
 - (b) recovery of overpayments; and
 - (c) consistent with Section 26-20-13, and to the extent permitted by law and quality control services, enforcement of fraud and abuse laws.
- (6) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:
 - (a) termination from the program;
 - (b) recovery of claim reimbursements incorrectly paid; and
 - (c) those specified in Section 1919 of Title XIX of the federal Social Security Act.
- (7) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as dedicated credits to be used by the division in accordance with the requirements of Section 1919 of Title XIX of the federal Social Security Act.
- (8)
 - (a) In determining whether an applicant or recipient is eligible for a service or benefit under this part or Chapter 40, Utah Children's Health Insurance Act, the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.
 - (b) Before Subsection (8)(a) may be applied:
 - (i) the federal government shall:
 - (A) determine that Subsection (8)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;
 - (B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or
 - (C) determine that the state's waivers that permit dual eligibility determinations for cash assistance and Medicaid are no longer valid; and
 - (ii) the department shall determine that Subsection (8)(a) can be implemented within existing funding.
- (9)

- (a) For purposes of this Subsection (9):
 - (i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as defined in 42 U.S.C. Sec. 1382c(a)(1); and
 - (ii) "spend down" means an amount of income in excess of the allowable income standard that shall be paid in cash to the department or incurred through the medical services not paid by Medicaid.
- (b) In determining whether an applicant or recipient who is aged, blind, or has a disability is eligible for a service or benefit under this chapter, the department shall use 100% of the federal poverty level as:
 - (i) the allowable income standard for eligibility for services or benefits; and
 - (ii) the allowable income standard for eligibility as a result of spend down.
- (10) The department shall conduct internal audits of the Medicaid program.
- (11)
 - (a) The department may apply for and, if approved, implement a demonstration program for health opportunity accounts, as provided for in 42 U.S.C. Sec. 1396u-8.
 - (b) A health opportunity account established under Subsection (11)(a) shall be an alternative to the existing benefits received by an individual eligible to receive Medicaid under this chapter.
 - (c) Subsection (11)(a) is not intended to expand the coverage of the Medicaid program.

Amended by Chapter 168, 2016 General Session

26-18-3.1 Medicaid expansion.

- (1) The purpose of this section is to expand the coverage of the Medicaid program to persons who are in categories traditionally not served by that program.
- (2) Within appropriations from the Legislature, the department may amend the state plan for medical assistance to provide for eligibility for Medicaid:
 - (a) on or after July 1, 1994, for children 12 to 17 years old who live in households below the federal poverty income guideline; and
 - (b) on or after July 1, 1995, for persons who have incomes below the federal poverty income guideline and who are aged, blind, or have a disability.
- (3)
 - (a) Within appropriations from the Legislature, on or after July 1, 1996, the Medicaid program may provide for eligibility for persons who have incomes below the federal poverty income guideline.
 - (b) In order to meet the provisions of this subsection, the department may seek approval for a demonstration project under 42 U.S.C. Section 1315 from the secretary of the United States Department of Health and Human Services. This demonstration project may also provide for the voluntary participation of private firms that:
 - (i) are newly established or marginally profitable;
 - (ii) do not provide health insurance to their employees;
 - (iii) employ predominantly low wage workers; and
 - (iv) are unable to obtain adequate and affordable health care insurance in the private market.
- (4) Services available for persons described in this section shall include required Medicaid services and may include one or more optional Medicaid services if those services are funded by the Legislature. The department may also require persons described in this section to meet an asset test.

Amended by Chapter 366, 2011 General Session

26-18-3.2 Release of financial information.

- (1)
 - (a) Upon request from a hospital, or a designated agent of a hospital, a bank or other financial institution shall provide the hospital, or the designated agent of the hospital, financial records of a patient upon the receipt of a notarized document that includes the following patient information:
 - (i) name;
 - (ii) address;
 - (iii) Social Security number; and
 - (iv) patient permission to release the information required by this Subsection (1) to the bank or financial institution.
 - (b) The document required by this Subsection (1) shall be signed by the patient and acknowledged by a notary public.
- (2) A hospital, or a designated agent of the hospital, may only request the information required under Subsection (1), if the hospital or the agent of the hospital:
 - (a) determines that the patient has no ability to pay; and
 - (b) has received adequate documentation from the patient, such as a valid driver license or passport, to verify the identity of the patient.

Enacted by Chapter 347, 2010 General Session

26-18-3.5 Copayments by recipients -- Employer sponsored plans.

- (1) The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.
- (2)
 - (a) The department shall seek approval under the department's Section 1115 Medicaid waiver to cap enrollment fees for the Primary Care Network Demonstration Project in accordance with Subsection (2)(b).
 - (b) Pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at \$15 per year for those persons who, after July 1, 2003, are eligible to begin receiving General Assistance under Section 35A-3-401.
 - (c) Beginning July 1, 2004, and pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at \$25 per year for those persons who have an income level that is below 50% of the federal poverty level.
- (3) Beginning May 1, 2006, within appropriations by the Legislature and as a means to increase health care coverage among the uninsured, the department shall take steps to promote increased participation in employer sponsored health insurance, including:
 - (a) maximizing the health insurance premium subsidy provided under the state's Primary Care Network Demonstration Project by:
 - (i) ensuring that state funds are matched by federal funds to the greatest extent allowable; and
 - (ii) as the department determines appropriate, seeking federal approval to do one or more of the following:
 - (A) eliminate or otherwise modify the annual enrollment fee;
 - (B) eliminate or otherwise modify the schedule used to determine the level of subsidy provided to an enrollee each year;
 - (C) reduce the maximum number of participants allowable under the subsidy program; or

- (D) otherwise modify the program in a manner that promotes enrollment in employer sponsored health insurance; and
- (b) exploring the use of other options, including the development of a waiver under the Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

Amended by Chapter 148, 2006 General Session

26-18-3.6 Income and resources from institutionalized spouses.

- (1) As used in this section:
 - (a) "Community spouse" means the spouse of an institutionalized spouse.
 - (b)
 - (i) "Community spouse monthly income allowance" means an amount by which the minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly income otherwise available to the community spouse, determined without regard to the allowance, except as provided in Subsection (1)(b)(ii).
 - (ii) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse may not be less than the amount of the monthly income so ordered.
 - (c) "Community spouse resource allowance" is an amount by which the greatest of the following exceeds the amount of the resources otherwise available to the community spouse:
 - (i) \$15,804;
 - (ii) the lesser of the spousal share computed under Subsection (4) or \$76,740;
 - (iii) the amount established in a hearing held under Subsection (11); or
 - (iv) the amount transferred by court order under Subsection (12)(c).
 - (d) "Excess shelter allowance" for a community spouse means the amount by which the sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case of condominium or cooperative, required maintenance charge, for the community spouse's principal residence and the spouse's actual expenses for electricity, natural gas, and water utilities or, at the discretion of the department, the federal standard utility allowance under SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection (9).
 - (e) "Family member" means a minor dependent child, dependent parents, or dependent sibling of the institutionalized spouse or community spouse who are residing with the community spouse.
 - (f)
 - (i) "Institutionalized spouse" means a person who is residing in a nursing facility and is married to a spouse who is not in a nursing facility.
 - (ii) An "institutionalized spouse" does not include a person who is not likely to reside in a nursing facility for at least 30 consecutive days.
 - (g) "Nursing care facility" is defined in Section 26-21-2.
- (2) The division shall comply with this section when determining eligibility for medical assistance for an institutionalized spouse.
- (3) For services furnished during a calendar year beginning on or after January 1, 1999, the dollar amounts specified in Subsections (1)(c)(i), (1)(c)(ii), and (10)(b) shall be increased by the division by the amount as determined annually by the federal Centers for Medicare and Medicaid Services.
- (4) The division shall compute, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse:

- (a) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest; and
 - (b) a spousal share, which is 1/2 of the resources described in Subsection (4)(a).
- (5) At the request of an institutionalized spouse or a community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the division shall promptly assess and document the total value described in Subsection (4)(a) and shall provide a copy of that assessment and documentation to each spouse and shall retain a copy of the assessment. When the division provides a copy of the assessment, it shall include a notice stating that the spouse may request a hearing under Subsection (11).
- (6) When determining eligibility for medical assistance under this chapter:
- (a) Except as provided in Subsection (6)(b), all the resources held by either the institutionalized spouse, community spouse, or both, are considered to be available to the institutionalized spouse.
 - (b) Resources are considered to be available to the institutionalized spouse only to the extent that the amount of those resources exceeds the amounts specified in Subsections (1)(c)(i) through (iv) at the time of application for medical assistance under this chapter.
- (7) The division may not find an institutionalized spouse to be ineligible for medical assistance by reason of resources determined under Subsection (5) to be available for the cost of care when:
- (a) the institutionalized spouse has assigned to the state any rights to support from the community spouse;
 - (b)
 - (i) except as provided in Subsection (7)(b)(ii), the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment;
 - (ii) Subsection (7)(b)(i) does not prevent the division from seeking a court order seeking an assignment of support; or
 - (c) the division determines that denial of medical assistance would cause an undue burden.
- (8) During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is eligible for medical assistance, the resources of the community spouse may not be considered to be available to the institutionalized spouse.
- (9) When an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly for the cost of care in the nursing care facility, the division shall deduct from the spouse's monthly income the following amounts in the following order:
- (a) a personal needs allowance, the amount of which is determined by the division;
 - (b) a community spouse monthly income allowance, but only to the extent that the income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;
 - (c) a family allowance for each family member, equal to at least 1/3 of the amount that the amount described in Subsection (10)(a)(i) exceeds the amount of monthly income of that family member; and
 - (d) amounts for incurred expenses for the medical or remedial care for the institutionalized spouse.
- (10)
- (a) Except as provided in Subsection (10)(b), the division shall establish a minimum monthly maintenance needs allowance for each community spouse which is not less than the sum of:
 - (i) 150% of the current poverty guideline for a two-person family unit that applies to this state as established by the United States Department of Health and Human Services; and
 - (ii) an excess shelter allowance.

(b) The amount provided in Subsection (10)(a) may not exceed \$1,976, unless a court order establishes a higher amount.

(11)

(a) An institutionalized spouse or a community spouse may request a hearing with respect to the determinations described in Subsections (11)(e)(i) through (v) if an application for medical assistance has been made on behalf of the institutionalized spouse.

(b) A hearing under this subsection regarding the community spouse resource allowance shall be held by the division within 90 days from the date of the request for the hearing.

(c) If either spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance provided under Subsection (10), an amount adequate to provide additional income as is necessary.

(d) If either spouse establishes that the community spouse resource allowance, in relation to the amount of income generated by the allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance, an amount adequate to provide a minimum monthly maintenance needs allowance.

(e) A hearing may be held under this subsection if either the institutionalized spouse or community spouse is dissatisfied with a determination of:

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse;

(iii) the computation of the spousal share of resources under Subsection (4);

(iv) the attribution of resources under Subsection (6); or

(v) the determination of the community spouse resource allocation.

(12)

(a) An institutionalized spouse may transfer an amount equal to the community spouse resource allowance, but only to the extent the resources of the institutionalized spouse are transferred to or for the sole benefit of the community spouse.

(b) The transfer under Subsection (12)(a) shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account the time necessary to obtain a court order under Subsection (12)(c).

(c) Chapter 19, Medical Benefits Recovery Act, does not apply if a court has entered an order against an institutionalized spouse for the support of the community spouse.

Amended by Chapter 258, 2015 General Session

26-18-3.8 Maximizing use of premium assistance programs -- Utah's Premium Partnership for Health Insurance.

(1)

(a) The department shall seek to maximize the use of Medicaid and Children's Health Insurance Program funds for assistance in the purchase of private health insurance coverage for Medicaid-eligible and non-Medicaid-eligible individuals.

(b) The department's efforts to expand the use of premium assistance shall:

(i) include, as necessary, seeking federal approval under all Medicaid and Children's Health Insurance Program premium assistance provisions of federal law, including provisions of the Patient Protection and Affordable Care Act, Public Law 111-148;

- (ii) give priority to, but not be limited to, expanding the state's Utah Premium Partnership for Health Insurance Program, including as required under Subsection (2); and
- (iii) encourage the enrollment of all individuals within a household in the same plan, where possible, including enrollment in a plan that allows individuals within the household transitioning out of Medicaid to retain the same network and benefits they had while enrolled in Medicaid.
- (c) Any increase in state costs resulting from an expansion of premium assistance may not exceed offsetting reductions in Medicaid and Children's Health Insurance Program state costs attributable to the expansion.
- (2) The department shall seek federal approval of an amendment to the state's Utah Premium Partnership for Health Insurance program to adjust the eligibility determination for single adults and parents who have an offer of employer sponsored insurance. The amendment shall:
 - (a) be within existing appropriations for the Utah Premium Partnership for Health Insurance program; and
 - (b) provide that adults who are up to 200% of the federal poverty level are eligible for premium subsidies in the Utah Premium Partnership for Health Insurance program.

Amended by Chapter 137, 2013 General Session

26-18-4 Department standards for eligibility under Medicaid -- Funds for abortions.

- (1) The department may develop standards and administer policies relating to eligibility under the Medicaid program as long as they are consistent with Subsection 26-18-3(8). An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.
- (2) The department may not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.
- (3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.
- (4) Any person or organization that, under the guise of other medical treatment, provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

Amended by Chapter 167, 2013 General Session

26-18-5 Contracts for provision of medical services -- Federal provisions modifying department rules -- Compliance with Social Security Act.

- (1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other state agencies, contracts shall provide that other state agencies transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.
- (2) All contracts for the provision or purchase of medical services shall be established on the basis of the state's fiscal year and shall remain uniform during the fiscal year insofar as possible. Contract terms shall include provisions for maintenance, administration, and service costs.

- (3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation; providing, the provisions of this section do not apply to department rules governing abortion.
- (4) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

Amended by Chapter 297, 2011 General Session

26-18-6 Federal aid -- Authority of executive director.

The executive director, with the approval of the governor, may bind the state to any executive or legislative provisions promulgated or enacted by the federal government which invite the state to participate in the distribution, disbursement or administration of any fund or service advanced, offered or contributed in whole or in part by the federal government for purposes consistent with the powers and duties of the department. Such funds shall be used as provided in this chapter and be administered by the department for purposes related to medical assistance programs.

Enacted by Chapter 126, 1981 General Session

26-18-7 Medical vendor rates.

Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division. As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

Amended by Chapter 21, 1988 General Session

26-18-8 Enforcement of public assistance statutes.

- (1) The department shall enforce or contract for the enforcement of Sections 35A-1-503, 35A-3-108, 35A-3-110, 35A-3-111, 35A-3-112, and 35A-3-603 insofar as these sections pertain to benefits conferred or administered by the division under this chapter.
- (2) The department may contract for services covered in Section 35A-3-111 insofar as that section pertains to benefits conferred or administered by the division under this chapter.

Amended by Chapter 90, 2003 General Session

26-18-9 Prohibited acts of state or local employees of Medicaid program -- Violation a misdemeanor.

Each state or local employee responsible for the expenditure of funds under the state Medicaid program, each individual who formerly was such an officer or employee, and each partner of such an officer or employee is prohibited for a period of one year after termination of such responsibility from committing any act, the commission of which by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by Section 207 or Section 208 of Title 18, United States Code. Violation of this section is a class A misdemeanor.

Enacted by Chapter 126, 1981 General Session

26-18-10 Utah Medical Assistance Program -- Policies and standards.

- (1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.
- (2) Persons in the custody of prisons, jails, halfway houses, and other nonmedical government institutions are not eligible for services provided under this section.
- (3) The department shall develop standards and administer policies relating to eligibility requirements, consistent with Subsection 26-18-3(8), for participation in the program, and for payment of medical claims for eligible persons.
- (4) The program shall be a payor of last resort. Before assistance is rendered the division shall investigate the availability of the resources of the spouse, father, mother, and adult children of the person making application.
- (5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.
- (6) The department may not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the mother would be endangered if an abortion were not performed.
- (7) The department may establish rules to carry out the provisions of this section.

Amended by Chapter 167, 2013 General Session

26-18-11 Rural hospitals.

- (1) For purposes of this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.
- (2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing may not discriminate among rural hospitals on the basis of size.

Amended by Chapter 297, 2011 General Session

26-18-13 Telemedicine -- Reimbursement -- Rulemaking.

- (1)
 - (a) On or after July 1, 2008, communication by telemedicine is considered face to face contact between a health care provider and a patient under the state's medical assistance program if:
 - (i) the communication by telemedicine meets the requirements of administrative rules adopted in accordance with Subsection (3); and
 - (ii) the health care services are eligible for reimbursement under the state's medical assistance program.
 - (b) This Subsection (1) applies to any managed care organization that contracts with the state's medical assistance program.
- (2) The reimbursement rate for telemedicine services approved under this section:
 - (a) shall be subject to reimbursement policies set by the state plan; and
 - (b) may be based on:
 - (i) a monthly reimbursement rate;
 - (ii) a daily reimbursement rate; or
 - (iii) an encounter rate.

- (3) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish:
- (a) the particular telemedicine services that are considered face to face encounters for reimbursement purposes under the state's medical assistance program; and
 - (b) the reimbursement methodology for the telemedicine services designated under Subsection (3)(a).

Enacted by Chapter 41, 2008 General Session

26-18-14 Strategic plan for health system reform -- Medicaid program.

- The department, including the Division of Health Care Financing within the department, shall:
- (1) work with the Governor's Office of Economic Development, the Insurance Department, the Department of Workforce Services, and the Legislature to develop health system reform in accordance with the strategic plan described in Title 63N, Chapter 11, Health System Reform Act;
 - (2) develop and submit amendments and waivers for the state's Medicaid plan as necessary to carry out the provisions of the Health System Reform Act;
 - (3) seek federal approval of an amendment to Utah's Premium Partnership for Health Insurance that would allow the state's Medicaid program to subsidize the purchase of health insurance by an individual who does not have access to employer sponsored health insurance;
 - (4) in coordination with the Department of Workforce Services:
 - (a) establish a Children's Health Insurance Program eligibility policy, consistent with federal requirements and Subsection 26-40-105(1)(d), that prohibits enrollment of a child in the program if the child's parent qualifies for assistance under Utah's Premium Partnership for Health Insurance; and
 - (b) involve community partners, insurance agents and producers, community based service organizations, and the education community to increase enrollment of eligible employees and individuals in Utah's Premium Partnership for Health Insurance and the Children's Health Insurance Program; and
 - (5) as funding permits, and in coordination with the department's adoption of standards for the electronic exchange of clinical health data, help the private sector form an alliance of employers, hospitals and other health care providers, patients, and health insurers to develop and use evidence-based health care quality measures for the purpose of improving health care decision making by health care providers, consumers, and third party payers.

Amended by Chapter 283, 2015 General Session

26-18-15 Process to promote health insurance coverage for children.

- (1) The Department of Workforce Services, the State Board of Education, and the department shall:
 - (a) collaborate with one another to develop a process to promote health insurance coverage for a child in school when:
 - (i) the child applies for free or reduced price school lunch;
 - (ii) a child enrolls in or registers in school; and
 - (iii) other appropriate school related opportunities;
 - (b) report to the Legislature on the development of the process under Subsection (1)(a) no later than November 19, 2008; and

- (c) implement the process developed under Subsection (1)(a) no later than the 2009-10 school year.
- (2) The Department of Workforce Services shall promote and facilitate the enrollment of children identified under Subsection (1)(a) without health insurance in the Utah Children's Health Insurance Program, the Medicaid program, or the Utah Premium Partnership for Health Insurance Program.

Enacted by Chapter 390, 2008 General Session

26-18-16 Medicaid -- Continuous eligibility -- Promoting payment and delivery reform.

- (1) In accordance with Subsection (2), and within appropriations from the Legislature, the department may amend the state Medicaid plan to:
 - (a) create continuous eligibility for up to 12 months for an individual who has qualified for the state Medicaid program;
 - (b) provide incentives in managed care contracts for an individual to obtain appropriate care in appropriate settings; and
 - (c) require the managed care system to accept the risk of managing the Medicaid population assigned to the plan amendment in return for receiving the benefits of providing quality and cost effective care.
- (2) If the department amends the state Medicaid plan under Subsection (1)(a) or (b), the department:
 - (a) shall ensure that the plan amendment:
 - (i) is cost effective for the state Medicaid program;
 - (ii) increases the quality and continuity of care for recipients; and
 - (iii) calculates and transfers administrative savings from continuous enrollment from the Department of Workforce Services to the Department of Health; and
 - (b) may limit the plan amendment under Subsection (1)(a) or (b) to select geographic areas or specific Medicaid populations.
- (3) The department may seek approval for a state plan amendment, waiver, or a demonstration project from the Secretary of Health and Human Services if necessary to implement a plan amendment under Subsection (1)(a) or (b).

Enacted by Chapter 155, 2012 General Session

26-18-17 Patient notice of health care provider privacy practices.

- (1)
 - (a) For purposes of this section:
 - (i) "Health care provider" means a health care provider as defined in Section 78B-3-403 who:
 - (A) receives payment for medical services from the Medicaid program established in this chapter, or the Children's Health Insurance Program established in Chapter 40, Utah Children's Health Insurance Act; and
 - (B) submits a patient's personally identifiable information to the Medicaid eligibility database or the Children's Health Insurance Program eligibility database.
 - (ii) "HIPAA" means 45 C.F.R. Parts 160, 162, and 164, Health Insurance Portability and Accountability Act of 1996, as amended.
 - (b) Beginning July 1, 2013, this section applies to the Medicaid program, the Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act, and a health care provider.

- (2) A health care provider shall, as part of the notice of privacy practices required by HIPAA, provide notice to the patient or the patient's personal representative that the health care provider either has, or may submit, personally identifiable information about the patient to the Medicaid eligibility database and the Children's Health Insurance Program eligibility database.
- (3) The Medicaid program and the Children's Health Insurance Program may not give a health care provider access to the Medicaid eligibility database or the Children's Health Insurance Program eligibility database unless the health care provider's notice of privacy practices complies with Subsection (2).
- (4) The department may adopt an administrative rule to establish uniform language for the state requirement regarding notice of privacy practices to patients required under Subsection (2).

Enacted by Chapter 53, 2013 General Session

26-18-18 Optional Medicaid expansion.

- (1) For purposes of this section, "PPACA" means the same as that term is defined in Section 31A-1-301.
- (2) The department and the governor shall not expand the state's Medicaid program to the optional population under PPACA unless:
 - (a) the governor or the governor's designee has reported the intention to expand the state Medicaid program under PPACA to the Legislature in compliance with the legislative review process in Sections 63N-11-106 and 26-18-3; and
 - (b) notwithstanding Subsection 63J-5-103(2), the governor submits the request for expansion of the Medicaid program for optional populations to the Legislature under the high impact federal funds request process required by Section 63J-5-204, Legislative review and approval of certain federal funds request.
- (3) The department shall request approval from the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services for waivers from federal statutory and regulatory law necessary to implement the health coverage improvement program under Section 26-18-411. The health coverage improvement program under Section 26-18-411 is not Medicaid expansion for purposes of this section.

Amended by Chapter 279, 2016 General Session

26-18-19 Medicaid vision services -- Request for proposals.

The department may select one or more contractors, in accordance with Title 63G, Chapter 6a, Utah Procurement Code, to provide vision services to the Medicaid populations that are eligible for vision services, as described in department rules, without restricting provider participation, and within existing appropriations from the Legislature.

Amended by Chapter 114, 2016 General Session

26-18-20 Review of claims -- Audit and investigation procedures.

- (1)
 - (a) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consultation with providers and health care professionals subject to audit and investigation under the state Medicaid program, to establish procedures for audits and investigations that are fair and consistent with the duties of the

department as the single state agency responsible for the administration of the Medicaid program under Section 26-18-3 and Title XIX of the Social Security Act.

- (b) If the providers and health care professionals do not agree with the rules proposed or adopted by the department under Subsection (1)(a), the providers or health care professionals may:
 - (i) request a hearing for the proposed administrative rule or seek any other remedies under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
 - (ii) request a review of the rule by the Legislature's Administrative Rules Review Committee created in Section 63G-3-501.
- (2) The department shall:
 - (a) notify and educate providers and health care professionals subject to audit and investigation under the Medicaid program of the providers' and health care professionals' responsibilities and rights under the administrative rules adopted by the department under the provisions of this section;
 - (b) ensure that the department, or any entity that contracts with the department to conduct audits:
 - (i) has on staff or contracts with a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited; and
 - (ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if the provider who is the subject of the audit disputes the findings of the audit;
 - (c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, as defined in Section 63A-13-102, unless:
 - (i) there is a determination that the level of payment error involving the provider exceeds a 10% error rate:
 - (A) for a sample of claims for a particular service code; and
 - (B) over a three year period of time;
 - (ii) documented education intervention has failed to correct the level of payment error; and
 - (iii) the value of the claims for the provider, in aggregate, exceeds \$200,000 in reimbursement for a particular service code on an annual basis; and
 - (d) require that any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.
- (3)
 - (a) If the department, or a contractor on behalf of the department:
 - (i) intends to implement the use of extrapolation as a method of auditing claims, the department shall, prior to adopting the extrapolation method of auditing, report its intent to use extrapolation to the Social Services Appropriations Subcommittee; and
 - (ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the department or the contractor may use extrapolation only for the service code associated with the findings under Subsections (2)(c)(i) through (iii).
 - (b)
 - (i) If extrapolation is used under this section, a provider may, at the provider's option, appeal the results of the audit based on:
 - (A) each individual claim; or
 - (B) the extrapolation sample.
 - (ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G, General Government, Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid program and its manual or rules, or other laws or rules that may provide remedies to providers.

