HB0344S01 compared with HB0344

~~{deleted text}~~ shows text that was in HB0344 but was deleted in HB0344S01.

inserted text shows text that was not in HB0344 but was inserted into HB0344S01.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative Steve R. Christiansen proposes the following substitute bill:

PROGRAM ELIGIBILITY AMENDMENTS

2021 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Steve R. Christiansen

Senate Sponsor: _____

LONG TITLE

General Description:

This bill modifies the responsibilities state agencies have regarding federal public assistance programs.

Highlighted Provisions:

This bill:

- defines terms;
- allows the Department of Health (DOH) to contract with a third-party vendor to assist with verifying Medicaid eligibility;
- removes DOH's ability to receive automated data matching from financial institutions;
- requires a benefit recipient to agree to disclose certain information before the recipient is eligible for benefits;

- requires certain state entities to regularly share information with DOH and the Department of Workforce Services (DWS) to determine if an individual has experienced a change in circumstances affecting the individual's eligibility for federal programs;
- requires DWS to regularly publish information regarding benefit fraud;
- requires DOH and DWS to independently verify an individual's enrollment information;
- outlines DOH's duties when federal law prohibits DOH from removing an individual from the Medicaid program;
- requires DOH to apply for the following Medicaid waivers with the Centers for Medicare and Medicaid Services:
  - a waiver to remove the requirement that DOH use information it already possesses when determining eligibility;
  - a waiver to stop using pre-populating forms; and
  - a waiver to restrict presumptive eligibility to pregnant women and children;
- requires a hospital that makes presumptive eligibility determinations to meet certain standards or be barred from making eligibility determinations;
- codifies requirements for Supplemental Nutrition Assistance Program (SNAP) and Medicaid eligibility; and
- restricts DWS's use of categorical eligibility regarding SNAP benefits.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-18-2.5, as last amended by Laws of Utah 2019, Chapter 393

26-18-3, as last amended by Laws of Utah 2019, Chapters 104 and 253

26-18-3.9, as last amended by Laws of Utah 2020, Fifth Special Session, Chapter 4

ENACTS:

26-18-27, Utah Code Annotated 1953

26-18-28, Utah Code Annotated 1953

35A-3-119, Utah Code Annotated 1953

35A-3-120, Utah Code Annotated 1953

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

Section 1. Section **26-18-2.5** is amended to read:

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

(1) The department may apply for grants and accept donations to 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.

(2) (a) The department may enter into an agreement with a third-party vendor or 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:~~] manage data and ensure eligibility.

[~~(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 third-party vendor or financial institution for compliance with this Subsection (2), as provided in Section 7-1-1006.

(c) A third-party vendor or 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 (2).

(d) The department may disclose a financial record obtained from a third-party vendor or 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.

Section 2. Section **26-18-3** is amended to read:

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~~] In addition to other rules necessary to implement the program, 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[~~.~~];

(v) except when prohibited by federal law, a requirement that an applicant or enrollee consent to the disclosure of information to the department or the Department of Workforce Services that:

(A) the applicant, enrollee, or a third party possesses; and

(B) relates to the applicant or enrollee's age, residence, citizenship, employment, applications for employment, income, and financial resources; and

(vi) before any benefits may be authorized or reauthorized, a requirement that an applicant or enrollee meet all eligibility requirements.

(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;

(v) applies for or receives approval for a change in any capitation rate within the Medicaid program; or

(vi) 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) (a) 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.

(b) In accordance with Section 63J-1-602.2, sanctions collected under this Subsection (7) are nonlapsing.

(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.

(12) (a) (i) The department shall apply for, and if approved, implement an amendment to the state plan under this Subsection (12) for benefits for:

(A) medically needy pregnant women;

(B) medically needy children; and

(C) medically needy parents and caretaker relatives.

(ii) The department may implement the eligibility standards of Subsection (12)(b) for eligibility determinations made on or after the date of the approval of the amendment to the state plan.

(b) In determining whether an applicant is eligible for benefits described in Subsection

(12)(a)(i), the department shall:

(i) disregard resources held in an account in the savings plan created under Title 53B, Chapter 8a, Utah Educational Savings Plan, if the beneficiary of the account is:

(A) under the age of 26; and

(B) living with the account owner, as that term is defined in Section 53B-8a-102, or temporarily absent from the residence of the account owner; and

(ii) include the withdrawals from an account in the Utah Educational Savings Plan as resources for a benefit determination, if the withdrawal was not used for qualified higher education costs as that term is defined in Section 53B-8a-102.5.

(13) (a) The department may not deny or terminate eligibility for Medicaid solely because an individual is:

(i) incarcerated; and

(ii) not an inmate as defined in Section 64-13-1.

(b) Subsection (13)(a) does not require the Medicaid program to provide coverage for any services for an individual while the individual is incarcerated.

Section 3. Section **26-18-3.9** is amended to read:

26-18-3.9. Expanding the Medicaid program.

(1) As used in this section:

(a) "CMS" means the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services.

(b) "Federal poverty level" means the same as that term is defined in Section 26-18-411.

(c) "Medicaid expansion" means an expansion of the Medicaid program in accordance with this section.

(d) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26-36b-208.

(2) (a) As set forth in Subsections (2) through (5), eligibility criteria for the Medicaid program shall be expanded to cover additional low-income individuals.

(b) The department shall continue to seek approval from CMS to implement the Medicaid waiver expansion as defined in Section 26-18-415.

(c) The department may implement any provision described in Subsections

26-18-415(2)(b)(iii) through (viii) in a Medicaid expansion if the department receives approval from CMS to implement that provision.

(3) The department shall expand the Medicaid program in accordance with this Subsection (3) if the department:

(a) receives approval from CMS to:

(i) expand Medicaid coverage to eligible individuals whose income is below 95% of the federal poverty level;

(ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(b) for enrolling an individual in the Medicaid expansion under this Subsection (3); and

(iii) permit the state to close enrollment in the Medicaid expansion under this Subsection (3) if the department has insufficient funds to provide services to new enrollment under the Medicaid expansion under this Subsection (3);

(b) pays the state portion of costs for the Medicaid expansion under this Subsection (3) with funds from:

(i) the Medicaid Expansion Fund;

(ii) county contributions to the nonfederal share of Medicaid expenditures; or

(iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid expenditures; and

(c) closes the Medicaid program to new enrollment under the Medicaid expansion under this Subsection (3) if the department projects that the cost of the Medicaid expansion under this Subsection (3) will exceed the appropriations for the fiscal year that are authorized by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.

(4) (a) The department shall expand the Medicaid program in accordance with this Subsection (4) if the department:

(i) receives approval from CMS to:

(A) expand Medicaid coverage to eligible individuals whose income is below 95% of the federal poverty level;

(B) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for enrolling an individual in the Medicaid expansion under this Subsection (4); and

(C) permit the state to close enrollment in the Medicaid expansion under this

Subsection (4) if the department has insufficient funds to provide services to new enrollment under the Medicaid expansion under this Subsection (4);

(ii) pays the state portion of costs for the Medicaid expansion under this Subsection (4) with funds from:

(A) the Medicaid Expansion Fund;

(B) county contributions to the nonfederal share of Medicaid expenditures; or

(C) any other contributions, funds, or transfers from a nonstate agency for Medicaid expenditures; and

(iii) closes the Medicaid program to new enrollment under the Medicaid expansion under this Subsection (4) if the department projects that the cost of the Medicaid expansion under this Subsection (4) will exceed the appropriations for the fiscal year that are authorized by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.

(b) The department shall submit a waiver, an amendment to an existing waiver, or a state plan amendment to CMS to:

(i) administer federal funds for the Medicaid expansion under this Subsection (4) according to a per capita cap developed by the department that includes an annual inflationary adjustment, accounts for differences in cost among categories of Medicaid expansion enrollees, and provides greater flexibility to the state than the current Medicaid payment model;

(ii) limit[~~, in certain circumstances as defined by the department,~~], in accordance with Subsection 26-18-28(1) and for other circumstances as determined by the department, the ability of a qualified entity to determine presumptive eligibility for Medicaid coverage for an individual enrolled in a Medicaid expansion under this Subsection (4);

(iii) impose a lock-out period if an individual enrolled in a Medicaid expansion under this Subsection (4) violates certain program requirements as defined by the department;

(iv) allow an individual enrolled in a Medicaid expansion under this Subsection (4) to remain in the Medicaid program for up to a 12-month certification period as defined by the department; and

(v) allow federal Medicaid funds to be used for housing support for eligible enrollees in the Medicaid expansion under this Subsection (4).

(5) (a) (i) If CMS does not approve a waiver to expand the Medicaid program in

accordance with Subsection (4)(a) on or before January 1, 2020, the department shall develop proposals to implement additional flexibilities and cost controls, including cost sharing tools, within a Medicaid expansion under this Subsection (5) through a request to CMS for a waiver or state plan amendment.

(ii) The request for a waiver or state plan amendment described in Subsection (5)(a)(i) shall include:

(A) a path to self-sufficiency for qualified adults in the Medicaid expansion that includes employment and training as defined in 7 U.S.C. Sec. 2015(d)(4); and

(B) a requirement that an individual who is offered a private health benefit plan by an employer to enroll in the employer's health plan.

(iii) The department shall submit the request for a waiver or state plan amendment developed under Subsection (5)(a)(i) on or before March 15, 2020.

(b) Notwithstanding Sections 26-18-18 and 63J-5-204, and in accordance with this Subsection (5), eligibility for the Medicaid program shall be expanded to include all persons in the optional Medicaid expansion population under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance, on the earlier of:

(i) the day on which CMS approves a waiver to implement the provisions described in Subsections (5)(a)(ii)(A) and (B); or

(ii) July 1, 2020.

(c) The department shall seek a waiver, or an amendment to an existing waiver, from federal law to:

(i) implement each provision described in Subsections 26-18-415(2)(b)(iii) through (viii) in a Medicaid expansion under this Subsection (5);

(ii) limit, in certain circumstances as defined by the department, the ability of a qualified entity to determine presumptive eligibility for Medicaid coverage for an individual enrolled in a Medicaid expansion under this Subsection (5); and

(iii) impose a lock-out period if an individual enrolled in a Medicaid expansion under this Subsection (5) violates certain program requirements as defined by the department.

(d) The eligibility criteria in this Subsection (5) shall be construed to include all individuals eligible for the health coverage improvement program under Section 26-18-411.

(e) The department shall pay the state portion of costs for a Medicaid expansion under this Subsection (5) entirely from:

(i) the Medicaid Expansion Fund;

(ii) county contributions to the nonfederal share of Medicaid expenditures; or

(iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid expenditures.

(f) If the costs of the Medicaid expansion under this Subsection (5) exceed the funds available under Subsection (5)(e):

(i) the department may reduce or eliminate optional Medicaid services under this chapter; and

(ii) savings, as determined by the department, from the reduction or elimination of optional Medicaid services under Subsection (5)(f)(i) shall be deposited into the Medicaid Expansion Fund; and

(iii) the department may submit to CMS a request for waivers, or an amendment of existing waivers, from federal law necessary to implement budget controls within the Medicaid program to address the deficiency.

(g) If the costs of the Medicaid expansion under this Subsection (5) are projected by the department to exceed the funds available in the current fiscal year under Subsection (5)(e), including savings resulting from any action taken under Subsection (5)(f):

(i) the governor shall direct the Department of Health, Department of Human Services, and Department of Workforce Services to reduce commitments and expenditures by an amount sufficient to offset the deficiency:

(A) proportionate to the share of total current fiscal year General Fund appropriations for each of those agencies; and

(B) up to 10% of each agency's total current fiscal year General Fund appropriations;

(ii) the Division of Finance shall reduce allotments to the Department of Health, Department of Human Services, and Department of Workforce Services by a percentage:

(A) proportionate to the amount of the deficiency; and

(B) up to 10% of each agency's total current fiscal year General Fund appropriations; and

(iii) the Division of Finance shall deposit the total amount from the reduced allotments

described in Subsection (5)(g)(ii) into the Medicaid Expansion Fund.

(6) The department shall maximize federal financial participation in implementing this section, including by seeking to obtain any necessary federal approvals or waivers.

(7) 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 a Medicaid expansion.

(8) The department shall report to the Social Services Appropriations Subcommittee on or before November 1 of each year that a Medicaid expansion is operational:

(a) the number of individuals who enrolled in the Medicaid expansion;

(b) costs to the state for the Medicaid expansion;

(c) estimated costs to the state for the Medicaid expansion for the current and following fiscal years;

(d) recommendations to control costs of the Medicaid expansion; and

(e) as calculated in accordance with Subsections 26-36b-204(4) and 26-36c-204(2), the state's net cost of the qualified Medicaid expansion.

Section 4. Section **26-18-27** is enacted to read:

26-18-27. Medicaid eligibility verification.

(1) (a) The following entities shall provide the department with information that indicates a change of circumstances concerning Medicaid eligibility:

(i) the Office of Vital Records and Statistics;

(ii) the Department of Corrections;

(iii) a county jail for an individual incarcerated at least ~~{five}~~30 days as of the day on which the jail provides information to the department; and

(iv) the Department of Workforce Services.

(b) The information described in Subsection (1)(a) may include death certificates, employment history, wages, out-of-state electronic benefit transfers, and incarceration records.

(c) The department shall review the information described in Subsection (1)(a) at least once each month.

(2) The Department of Workforce Services shall publish on the Department of Workforce Services' website information regarding Medicaid and Children's Health Insurance Program non-compliance and fraud investigations, including the following aggregate,

non-confidential, and non-personally identifying information:

(a) the number of assistance cases investigated for an intentional program violation or fraud;

(b) the total number of assistance cases referred to the Office of the Attorney General for prosecution;

(c) the total amount of improper payments and expenditures;

(d) the total amount of money recovered;

(e) data concerning improper payments and ineligible recipients as a percentage of the payments investigated and reviewed; and

(f) the amount of funds expended by electronic benefit transactions in each state outside of Utah.

(3) The department shall publish a link to the Department of Workforce Services' website for the information described in Subsection (2).

(4) If the department receives information concerning an enrollee that indicates a change in circumstances that may affect the enrollee's eligibility, the department shall review the enrollee's case.

(5) If an exchange established under 42 U.S.C. Sec. 18041, determines an individual is eligible for the Medicaid program, the department may not accept the exchange's determination until the department:

(a) independently verifies the individual's eligibility information; and

(b) makes an eligibility determination.

(6) The department shall apply for a Medicaid waiver with CMS to enable the department to suspend the following Medicaid requirements:

(a) renewing eligibility automatically based on information the department already possesses; and

(b) using a pre-populated renewal form.

(7) Unless required under federal law, the department may not:

(a) designate the department as a qualified entity for the purpose of making presumptive eligibility determinations;

(b) enroll an individual in the Medicaid program based on self-attestation of income, residency, age, household composition, caretaker or relative status, or receipt of other coverage,

unless the department first verifies the information or determines that the individual is homeless or actively seeking shelter from domestic violence;

(c) request authority to decline to check any available income-related data sources to verify eligibility; or

(d) request authority to waive the public notice requirements applicable to proposed changes to the state plan under 42 C.F.R. Sec. 447.205, 42 C.F.R. Sec. 447.57, and 42 C.F.R. Sec. 440.386 unless the governor or the United States Department of Health and Human Services has declared a public health emergency.

(8) During a period where federal law, including maintenance of effort provisions under the Families First Coronavirus Response Act, Public Law 116-127, 134 Stat.178, restricts the department's ability to disenroll an individual from the Medicaid program, the department shall:

(a) continue to redetermine eligibility and take appropriate actions regarding the individual's eligibility to the extent possible under federal law;

(b) as soon as possible but not longer than 120 days after the day on which the period described in this Subsection (8) ends, the department shall:

(i) redetermine eligibility for each case that the department has not redetermined within the last 12 months;

(ii) for an enrollee first enrolled during the period described in this Subsection (8), or enrolled longer than three months during the period described in this Subsection (8):

(A) request federal approval from CMS for the authority to temporarily suspend the annual redetermination limitation; and

(B) if CMS grants the authority described in Subsection (8)(b)(ii)(A) without a decrease in federal matching funds, redetermine the enrollee's eligibility and take appropriate action; and

(iii) verify all information as required under state law;

(c) prepare a report regarding information the department obtains while enforcing Subsection (8)(b); and

(d) submit the report described in Subsection (8)(c) to the Social Services Appropriations Subcommittee within one year after the day on which the period described in this Subsection (8) ends.

Section 5. Section **26-18-28** is enacted to read:

26-18-28. Hospital presumptive eligibility.

(1) (a) The department shall apply for a Medicaid waiver with CMS to enable the department to restrict hospital presumptive eligibility determinations to pregnant women and children only.

(b) The department shall:

(i) submit the waiver request described in Subsection (1)(a) before January 1, 2022; and

(ii) resubmit a waiver request within fifty-two months from January 1, 2022, if CMS denies a request described in Subsection (1)(a).

(2) A hospital that makes a presumptive eligibility determination shall:

(a) notify the department of the presumptive eligibility determination within five business days after the day on which the hospital makes the determination;

(b) assist the individual with completing and submitting a full Medicaid application form;

(c) notify the applicant in writing and on all relevant forms with plain language and large print that if the applicant does not submit a full Medicaid application with the department before the last day of the following month, the applicant's presumptive eligibility coverage will end on that last day; and

(d) notify the applicant that if the applicant submits a full Medicaid application to the department before the last day of the following month, presumptive eligibility coverage will continue until the department makes an eligibility determination on the application.

(3) The department shall use the following standards to evaluate each presumptive eligibility determination made by a hospital and inform the hospital regarding any deficiencies:

(a) whether the department received adequate notice of the presumptive eligibility determination within five business days after the day on which the determination was made;

(b) whether the department received a full Medicaid application before the expiration of the presumptive eligibility period; and

(c) if the department received a full application before the expiration of the presumptive eligibility period, whether the department found the individual eligible for full Medicaid coverage.

(4) If a hospital violates a requirement described in Subsection (2), within five business days after the day on which the department discovers the violation, the department shall provide a notice to the hospital describing:

(a) the specific violation;

(b) the appeals process; and

(c) any potential penalties for a subsequent violation as described in Subsection (5).

(5) A hospital that violates Subsection (2), is subject to the following:

(a) after a second violation that occurs within one year after the day on which the department discovers the first violation, the department shall provide mandatory training for the hospital's staff who make presumptive eligibility determinations and develop a corrective action plan with the hospital; and

(b) after a third violation that occurs within one year after the day on which the department discovers the second violation, the hospital may not make presumptive eligibility determinations for five years.

(6) The department shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for implementing Subsection (5).

Section 6. Section **35A-3-119** is enacted to read:

35A-3-119. SNAP eligibility verification.

(1) The department shall, except when prohibited by federal law, require an applicant or enrollee to consent to the disclosure of information that:

(a) the applicant, enrollee, or a third party possesses; and

(b) relates to the applicant or enrollee's age, residence, citizenship, employment, applications for employment, income, or financial resources.

(2) The department may authorize or reauthorize SNAP benefits, only if the applicant or enrollee meets all eligibility requirements.

(3) (a) The following agencies shall provide the department with information that indicates a change of circumstances concerning SNAP eligibility:

(i) the Office of Vital Records and Statistics;

(ii) the Department of Corrections;

(iii) a county jail for an individual incarcerated at least ~~{five}~~30 days as of the day on which the jail provides information to the department; and

(iv) the Department of Health.

(b) The information described in Subsection (3)(a) may include death certificates, employment history, wages, out-of-state electronic benefit transfers, and incarceration records.

(c) The department shall review the information described in Subsection (3)(a) at least once each month.

(4) Each quarter, the department shall publish on the department's website information regarding non-compliance and fraud investigations, including the following aggregate, non-confidential, and non-personally identifying information:

(a) the number of assistance cases investigated for intentional program violations or fraud;

(b) the total number of assistance cases referred to the Office of the Attorney General for prosecution;

(c) the total amount of improper payments and expenditures;

(d) the total amount of money recovered;

(e) data concerning improper payments and ineligible recipients as a percentage of the payments investigated and reviewed; and

(f) the amount of funds expended by electronic benefit transactions in each state outside of Utah.

(5) If the department receives information concerning an individual receiving SNAP benefits that indicates a change in circumstances that may affect the individual's eligibility, the department shall review the individual or household's case.

(6) The department may execute a memorandum of understanding with another government entity described in Subsection (3)(a) to share the information described in Subsection (3).

Section 7. Section **35A-3-120** is enacted to read:

35A-3-120. Benefit reporting -- child support -- categorical eligibility.

~~{ (1) After June 30, 2022, the department shall require:~~

~~}~~ (~~{a}~~1) ~~{notwithstanding}~~Notwithstanding any other provision of law, the department shall require a household receiving SNAP benefits to report a change in circumstances, as described in 7 C.F.R. Sec. 273.12(a)(1), within 10 days after the day on which the change is known to the household~~{; and}~~.

~~{ (b) an individual to cooperate with the child support enforcement program as a condition of eligibility for assistance in accordance with 7 C.F.R. Sec. 273.11(o) and 7 C.F.R. Sec. 273.11(p).~~

~~}~~ (2) Unless required by federal law, the department may not:

(a) grant categorical eligibility under 7 U.S.C. Sec. 2014(a) or 7 C.F.R. Sec. 273.2(j)(2)(iii) for any noncash, in-kind, or other benefit;

(b) apply a gross income standard that exceeds the standards described in 7 U.S.C. Sec. 2014(c); or

(c) exempt a household from gross income requirements under categorical eligibility for any noncash, in-kind, or other benefit.