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**Medicaid Amendments**  
2026 GENERAL SESSION  
STATE OF UTAH  
**Chief Sponsor: Steve Eliason**  
Senate Sponsor: Keith Grover

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**LONG TITLE**

**General Description:**

This bill amends provisions related to Medicaid.

**Highlighted Provisions:**

This bill:

- defines terms;
- changes the date Medicaid expansion will end if federal matching funds are reduced;
- requires the Department of Health and Human Services (department) to end certain programs that would lead to a reduction in federal matching funds for Medicaid expansion if the state participated in the program;
- requires the department to prepare a proposal if federal matching funds are reduced;
- amends provisions related to the targeted adult Medicaid program; and
- creates a reporting requirement.

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

None

**Utah Code Sections Affected:**

AMENDS:

- 26B-3-109 (Effective 05/06/26)**, as renumbered and amended by Laws of Utah 2023, Chapter 306
- 26B-3-113 (Effective 05/06/26)**, as last amended by Laws of Utah 2025, First Special Session, Chapter 16
- 26B-3-207 (Effective 05/06/26)**, as last amended by Laws of Utah 2025, First Special Session, Chapter 16

28 **26B-3-210 (Effective 05/06/26)**, as last amended by Laws of Utah 2024, Chapters 250,  
29 439

30 **26B-3-506 (Effective 05/06/26) (Repealed 07/01/34)**, as renumbered and amended by  
31 Laws of Utah 2023, Chapter 306

32 **26B-3-601 (Effective 05/06/26) (Repealed 07/01/34)**, as last amended by Laws of Utah  
33 2024, Chapter 439

34 **26B-3-606 (Effective 05/06/26) (Repealed 07/01/34)**, as renumbered and amended by  
35 Laws of Utah 2023, Chapter 306

36 **26B-3-707 (Effective 05/06/26) (Repealed 07/01/28)**, as last amended by Laws of Utah  
37 2024, Chapter 284

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

40 Section 1. Section **26B-3-109** is amended to read:

41 **26B-3-109 (Effective 05/06/26). Medicaid expansion.**

- 42 (1) The purpose of this section is to expand the coverage of the Medicaid program to  
43 persons who are in categories traditionally not served by that program.
- 44 (2) Within appropriations from the Legislature, the department may amend the state plan  
45 for medical assistance to provide for eligibility for Medicaid:
- 46 (a) on or after July 1, 1994, for children 12 to 17 years old who live in households below  
47 the federal poverty income guideline; and
- 48 (b) on or after July 1, 1995, for persons who have incomes below the federal poverty  
49 income guideline and who are aged, blind, or have a disability.
- 50 (3)(a) Within appropriations from the Legislature, on or after July 1, 1996, the Medicaid  
51 program may provide for eligibility for persons who have incomes below the federal  
52 poverty income guideline.
- 53 (b) In order to meet the provisions of this subsection, the department may seek approval  
54 for a demonstration project under 42 U.S.C. Sec. 1315 from the secretary of the  
55 United States Department of Health and Human Services.
- 56 (4) The Medicaid program shall provide for eligibility for ~~[persons as required by~~  
57 ~~Subsection 26B-3-113(2)]~~ individuals authorized to be enrolled in Medicaid under  
58 Sections 26B-3-113 and 26B-3-210.
- 59 (5) Services available for persons described in this section shall include required Medicaid  
60 services and may include one or more optional Medicaid services if those services are  
61 funded by the Legislature. The department may also require persons described in

62 Subsections (1) through (3) to meet an asset test.

63 Section 2. Section **26B-3-113** is amended to read:

64 **26B-3-113 (Effective 05/06/26). Expanding the Medicaid program.**

65 (1) As used in this section:

66 (a) "Federal poverty level" means the same as that term is defined in Section 26B-3-207.

67 (b) "Medicaid ACA Fund" means the Medicaid ACA Fund created in Section 26B-1-315.

68 (c) "Medicaid expansion" means an expansion of the Medicaid program in accordance  
69 with this section and Section 26B-3-210.

70 (2) Subject to Section 26B-3-210, the department has the authority to implement and  
71 operate Medicaid expansion as approved by CMS and state law.

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

74 [~~(b) The department shall continue to seek approval from CMS to implement the~~  
75 ~~Medicaid waiver expansion as defined in Section 26B-3-210.]~~

76 [~~(e) The department may implement any provision described in Subsections~~  
77 ~~26B-3-210(2)(b)(iii) through (viii) in a Medicaid expansion if the department~~  
78 ~~receives approval from CMS to implement that provision.]~~

79 [~~(3) The department shall expand the Medicaid program in accordance with this Subsection~~  
80 ~~(3) if the department:]~~

81 [~~(a) receives approval from CMS to:]~~

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

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

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

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

92 [~~(i) the Medicaid ACA Fund;]~~

93 [~~(ii) county contributions to the nonfederal share of Medicaid expenditures; or]~~

94 [~~(iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid~~  
95 ~~expenditures; and]~~

96           ~~[(e) closes the Medicaid program to new enrollment under the Medicaid expansion~~  
97           ~~under this Subsection (3) if the department projects that the cost of the Medicaid~~  
98           ~~expansion under this Subsection (3) will exceed the appropriations for the fiscal year~~  
99           ~~that are authorized by the Legislature through an appropriations act adopted in~~  
100           ~~accordance with Title 63J, Chapter 1, Budgetary Procedures Act.]~~  
101       ~~[(4)(a) The department shall expand the Medicaid program in accordance with this~~  
102           ~~Subsection (4) if the department:]~~  
103           ~~[(i) receives approval from CMS to:]~~  
104           ~~[(A) expand Medicaid coverage to eligible individuals whose income is below~~  
105           ~~95% of the federal poverty level;]~~  
106           ~~[(B) obtain maximum federal financial participation under 42 U.S.C. Sec.~~  
107           ~~1396d(y) for enrolling an individual in the Medicaid expansion under this~~  
108           ~~Subsection (4); and]~~  
109           ~~[(C) permit the state to close enrollment in the Medicaid expansion under this~~  
110           ~~Subsection (4) if the department has insufficient funds to provide services to~~  
111           ~~new enrollment under the Medicaid expansion under this Subsection (4);]~~  
112           ~~[(ii) pays the state portion of costs for the Medicaid expansion under this Subsection~~  
113           ~~(4) with funds from:]~~  
114           ~~[(A) the Medicaid ACA Fund;]~~  
115           ~~[(B) county contributions to the nonfederal share of Medicaid expenditures; or]~~  
116           ~~[(C) any other contributions, funds, or transfers from a nonstate agency for~~  
117           ~~Medicaid expenditures; and]~~  
118           ~~[(iii) closes the Medicaid program to new enrollment under the Medicaid expansion~~  
119           ~~under this Subsection (4) if the department projects that the cost of the Medicaid~~  
120           ~~expansion under this Subsection (4) will exceed the appropriations for the fiscal~~  
121           ~~year that are authorized by the Legislature through an appropriations act adopted~~  
122           ~~in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.]~~  
123       ~~[(b) The department shall submit a waiver, an amendment to an existing waiver, or a~~  
124           ~~state plan amendment to CMS to:]~~  
125           ~~[(i) administer federal funds for the Medicaid expansion under this Subsection (4)~~  
126           ~~according to a per capita cap developed by the department that includes an annual~~  
127           ~~inflationary adjustment, accounts for differences in cost among categories of~~  
128           ~~Medicaid expansion enrollees, and provides greater flexibility to the state than the~~  
129           ~~current Medicaid payment model;]~~

- 130 [(ii) limit, in certain circumstances as defined by the department, the ability of a  
131 qualified entity to determine presumptive eligibility for Medicaid coverage for an  
132 individual enrolled in a Medicaid expansion under this Subsection (4);]
- 133 [(iii) impose a lock-out period if an individual enrolled in a Medicaid expansion  
134 under this Subsection (4) violates certain program requirements as defined by the  
135 department;]
- 136 [(iv) allow an individual enrolled in a Medicaid expansion under this Subsection (4)  
137 to remain in the Medicaid program for up to a 12-month certification period as  
138 defined by the department; and]
- 139 [(v) allow federal Medicaid funds to be used for housing support for eligible  
140 enrollees in the Medicaid expansion under this Subsection (4).]
- 141 [(5)] (3)[(a)(i) If CMS does not approve a waiver to expand the Medicaid program in  
142 accordance with Subsection (4)(a) on or before January 1, 2020, the department  
143 shall develop proposals to implement additional flexibilities and cost controls,  
144 including cost sharing tools, within a Medicaid expansion under this Subsection  
145 (5) through a request to CMS for a waiver or state plan amendment.]
- 146 [(ii) The request for a waiver or state plan amendment described in Subsection  
147 (5)(a)(i) shall include:]
- 148 [(A) a path to self-sufficiency for qualified adults in the Medicaid expansion that  
149 includes employment and training as defined in 7 U.S.C. Sec. 2015(d)(4); and]
- 150 [(B) a requirement that an individual who is offered a private health benefit plan  
151 by an employer to enroll in the employer's health plan.]
- 152 [(iii) The department shall submit the request for a waiver or state plan amendment  
153 developed under Subsection (5)(a)(i) on or before March 15, 2020.]
- 154 [(b) Notwithstanding Sections 26B-3-127 and 63J-5-204, and in accordance with this  
155 Subsection (5), eligibility for the Medicaid program shall be expanded to include all  
156 persons in the optional Medicaid expansion population under PPACA and the Health  
157 Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal  
158 regulations and guidance, on the earlier of:]
- 159 [(i) the day on which CMS approves a waiver to implement the provisions described  
160 in Subsections (5)(a)(ii)(A) and (B); or]
- 161 [(ii) July 1, 2020.]
- 162 [(c) The department shall seek a waiver, or an amendment to an existing waiver, from  
163 federal law to:]

- 164 ~~[(i) implement each provision described in Subsections 26B-3-210(2)(b)(iii) through~~  
 165 ~~(viii) in a Medicaid expansion under this Subsection (5);]~~
- 166 ~~[(ii) limit, in certain circumstances as defined by the department, the ability of a~~  
 167 ~~qualified entity to determine presumptive eligibility for Medicaid coverage for an~~  
 168 ~~individual enrolled in a Medicaid expansion under this Subsection (5); and]~~
- 169 ~~[(iii) impose a lock-out period if an individual enrolled in a Medicaid expansion~~  
 170 ~~under this Subsection (5) violates certain program requirements as defined by the~~  
 171 ~~department.]~~
- 172 ~~[(d) The eligibility criteria in this Subsection (5) shall be construed to include all~~  
 173 ~~individuals eligible for the health coverage improvement program under Section~~  
 174 ~~26B-3-207.]~~
- 175 ~~[(e)]~~ (a) The department shall pay the state portion of costs for ~~[a-]~~Medicaid expansion [  
 176 ~~under this Subsection (5)]~~entirely from:
- 177 (i) the Medicaid ACA Fund;
- 178 (ii) county contributions to the nonfederal share of Medicaid expenditures; or
- 179 (iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid  
 180 expenditures.
- 181 ~~[(f)]~~ (b) If the costs of the Medicaid expansion ~~[under this Subsection (5)]~~exceed the  
 182 funds available under Subsection ~~[(5)(e)]~~ (3)(a):
- 183 (i) the department may reduce or eliminate optional Medicaid services under this  
 184 chapter;
- 185 (ii) savings, as determined by the department, from the reduction or elimination of  
 186 optional Medicaid services under Subsection ~~[(5)(f)(i)]~~ (3)(b)(i) shall be deposited  
 187 into the Medicaid ACA Fund; and
- 188 (iii) the department may submit to CMS a request for waivers, or an amendment of  
 189 existing waivers, from federal law necessary to implement budget controls within  
 190 the Medicaid program to address the deficiency.
- 191 ~~[(g)]~~ (c) If the costs of the Medicaid expansion ~~[under this Subsection (5)]~~are projected  
 192 by the department to exceed the funds available in the current fiscal year under  
 193 Subsection ~~[(5)(e)]~~ (3)(a), including savings resulting from any action taken under  
 194 Subsection ~~[(5)(f)]~~ (3)(b):
- 195 (i) the governor shall direct the department and Department of Workforce Services to  
 196 reduce commitments and expenditures by an amount sufficient to offset the  
 197 deficiency:

- 198 (A) proportionate to the share of total current fiscal year General Fund
- 199 appropriations for each of those agencies; and
- 200 (B) up to 10% of each agency's total current fiscal year General Fund
- 201 appropriations;
- 202 (ii) the Division of Finance shall reduce allotments to the department and Department
- 203 of Workforce Services by a percentage:
  - 204 (A) proportionate to the amount of the deficiency; and
  - 205 (B) up to 10% of each agency's total current fiscal year General Fund
  - 206 appropriations; and
- 207 (iii) the Division of Finance shall deposit the total amount from the reduced
- 208 allotments described in Subsection [~~(5)(g)(ii)~~] (3)(c)(ii) into the Medicaid ACA
- 209 Fund.

210 [~~(6)~~] (4) The department shall maximize federal financial participation in implementing this

211 section, including by seeking to obtain any necessary federal approvals or waivers.

212 [~~(7)~~] (5) Notwithstanding Sections 17-77-201 and 17-77-301, a county does not have to

213 provide matching funds to the state for the cost of providing Medicaid services to newly

214 enrolled individuals who qualify for Medicaid coverage under a Medicaid expansion.

215 [~~(8)~~] (6) The department shall report to the Social Services Appropriations Subcommittee on

216 or before November 1 of each year that a Medicaid expansion is operational:

- 217 (a) the number of individuals who enrolled in the Medicaid expansion;
- 218 (b) costs to the state for the Medicaid expansion;
- 219 (c) estimated costs to the state for the Medicaid expansion for the current and following
- 220 fiscal years;
- 221 (d) recommendations to control costs of the Medicaid expansion; and
- 222 (e) as calculated in accordance with Subsections 26B-3-506(4) and 26B-3-606(2), the
- 223 state's net cost of the [~~qualified~~]Medicaid expansion.

224 Section 3. Section **26B-3-207** is amended to read:

225 **26B-3-207 (Effective 05/06/26). Health coverage improvement program --**

226 **Eligibility -- Annual report -- Expansion of eligibility for adults with dependent children.**

227 (1) As used in this section:

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

- 232 (b) "Enhancement waiver program" means the Primary Care Network enhancement  
233 waiver program described in Section 26B-3-211.
- 234 (c) "Federal poverty level" means the poverty guidelines established by the Secretary of  
235 the United States Department of Health and Human Services under 42 U.S.C. Sec.  
236 9909(2).
- 237 (d) "Health coverage improvement program" means the health coverage improvement  
238 program described in Subsections (3) through (9).
- 239 (e) "Homeless":
- 240 (i) means an individual who is chronically homeless, as determined by the  
241 department; and
- 242 (ii) includes someone who was chronically homeless and is currently living in  
243 supported housing for the chronically homeless.
- 244 (f) "Income eligibility ceiling" means the percent of federal poverty level:
- 245 (i) established by the state in an appropriations act adopted pursuant to Title 63J,  
246 Chapter 1, Budgetary Procedures Act; and
- 247 (ii) under which an individual may qualify for Medicaid coverage in accordance with  
248 this section.
- 249 (g) "Targeted adult Medicaid program" means the program implemented by the  
250 department under Subsections (5) through (7).
- 251 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to allow  
252 temporary residential treatment for substance use, for the traditional Medicaid  
253 population, in a short term, non-institutional, 24-hour facility, without a bed capacity  
254 limit that provides rehabilitation services that are medically necessary and in accordance  
255 with an individualized treatment plan, as approved by CMS and as long as the county  
256 makes the required match under Section 17-77-201.
- 257 (3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to increase  
258 the income eligibility ceiling to a percentage of the federal poverty level designated by  
259 the department, based on appropriations for the program, for an individual with a  
260 dependent child.
- 261 (4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an  
262 amendment of existing waivers, from federal statutory and regulatory law necessary for  
263 the state to implement the health coverage improvement program in the Medicaid  
264 program in accordance with this section.
- 265 (5)(a) An adult in the expansion population is eligible for Medicaid if the adult meets the

- 266 income eligibility and other criteria established under Subsection (6).
- 267 (b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:
- 268 (i) through the traditional fee for service Medicaid model in counties without
- 269 Medicaid accountable care organizations or the state's Medicaid accountable care
- 270 organization delivery system, where implemented and subject to Section
- 271 26B-3-223;
- 272 (ii) except as provided in Subsection (5)(b)(iii), for behavioral health, through the
- 273 counties in accordance with Sections 17-77-201 and 17-77-301;
- 274 (iii) that, subject to Section 26B-3-223, integrates behavioral health services and
- 275 physical health services with Medicaid accountable care organizations in select
- 276 geographic areas of the state that choose an integrated model; and
- 277 (iv) that permits temporary residential treatment for substance use in a short term,
- 278 non-institutional, 24-hour facility, without a bed capacity limit, as approved by
- 279 CMS, that provides rehabilitation services that are medically necessary and in
- 280 accordance with an individualized treatment plan.
- 281 (6)(a) An individual is eligible for the health coverage improvement program under
- 282 Subsection (5) if:
- 283 (i) at the time of enrollment, the individual's annual income is below the income
- 284 eligibility ceiling established by the state under Subsection (1)(f); and
- 285 (ii) the individual meets the eligibility criteria established by the department under
- 286 Subsection (6)(b).
- 287 (b) Based on available funding and approval from CMS, the department shall select the
- 288 criteria for an individual to qualify for the Medicaid program under Subsection
- 289 (6)(a)(ii), based on the following priority:
- 290 (i) a chronically homeless individual;
- 291 (ii) if funding is available, an individual:
- 292 (A) involved in the justice system through probation, parole, or court ordered
- 293 treatment; and
- 294 (B) in need of substance use treatment or mental health treatment, as determined
- 295 by the department; or
- 296 (iii) if funding is available, an individual in need of substance use treatment or mental
- 297 health treatment, as determined by the department.
- 298 (c) ~~[An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)~~
- 299 ~~may remain on the Medicaid program for a 12-month certification period as defined~~

- 300 by the department. Eligibility changes made by the department under Subsection  
301 (1)(f) or (6)(b) shall not apply to an individual during the 12-month certification  
302 period.] Subject to Subsection (6)(d), if approved by CMS:
- 303 (i) an individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)  
304 may remain on the Medicaid program for a certification period not to exceed 12  
305 months; and
- 306 (ii) eligibility changes made by the department under Subsection (1)(f) or (6)(b) do  
307 not apply to an individual during the certification period.
- 308 (d)(i) The department may not seek approval from CMS to implement Subsection  
309 (6)(c) unless the executive director determines that CMS is likely to approve a  
310 waiver described in Subsection (6)(c).
- 311 (ii) If the executive director determines CMS is likely to approve a waiver described  
312 in Subsection (6)(c), the department shall apply for the waiver within 120 days of  
313 the determination.
- 314 (iii) When applying for the waiver, the department may alter the length of the  
315 certification period described in Subsection (6)(c)(i) as necessary to obtain the  
316 waiver if the length of the certification period does not exceed 12 months.
- 317 (7) The state may request a modification of the income eligibility ceiling and other  
318 eligibility criteria under Subsection (6) each fiscal year based on projected enrollment,  
319 costs to the state, and the state budget.
- 320 (8) The current Medicaid program and the health coverage improvement program, when  
321 implemented, shall coordinate with a state prison or county jail to expedite Medicaid  
322 enrollment for an individual who is released from custody and was eligible for or  
323 enrolled in Medicaid before incarceration.
- 324 (9) Notwithstanding Sections 17-77-201 and 17-77-301, a county does not have to provide  
325 matching funds to the state for the cost of providing Medicaid services to newly enrolled  
326 individuals who qualify for Medicaid coverage under the health coverage improvement  
327 program under Subsection (6).
- 328 (10) If the enhancement waiver program is implemented, the department:
- 329 (a) may not accept any new enrollees into the health coverage improvement program  
330 after the day on which the enhancement waiver program is implemented;
- 331 (b) shall transition all individuals who are enrolled in the health coverage improvement  
332 program into the enhancement waiver program;
- 333 (c) shall suspend the health coverage improvement program within one year after the

- 334 day on which the enhancement waiver program is implemented;
- 335 (d) shall, within one year after the day on which the enhancement waiver program is  
 336 implemented, use all appropriations for the health coverage improvement program to  
 337 implement the enhancement waiver program; and
- 338 (e) shall work with CMS to maintain any waiver for the health coverage improvement  
 339 program while the health coverage improvement program is suspended under  
 340 Subsection (10)(c).
- 341 (11) If, after the enhancement waiver program takes effect, the enhancement waiver  
 342 program is repealed or suspended by either the state or federal government, the  
 343 department shall reinstate the health coverage improvement program and continue to  
 344 accept new enrollees into the health coverage improvement program in accordance with  
 345 the provisions of this section.

346 Section 4. Section **26B-3-210** is amended to read:

347 **26B-3-210 (Effective 05/06/26). Medicaid expansion.**

348 (1) As used in this section:

349 (a) "Adult in the expansion population" means an individual who:

350 (i) is described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and

351 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy  
 352 individual.

353 (b) "Discrete program" means a program or benefit that:

354 (i) can be closed or ended with minimal impact on other state programs; and

355 (ii) receives less than \$50 million in state funds annually.

356 (c) "Expansion FMAP" means the Federal Medical Assistance Percentage described in  
 357 42 U.S.C. Sec. 1396d(y).

358 (d) "Federal poverty level" means the same as that term is defined in Section 26B-3-207.

359 ~~(b)~~ (e) "Medicaid [waiver-]expansion" [means an expansion of the Medicaid program in  
 360 accordance with this section] means the same as that term is defined in Section  
 361 26B-3-113.

362 ~~(2)(a) Before January 1, 2019, the department shall apply to CMS for approval of a~~  
 363 ~~waiver or state plan amendment to implement the Medicaid waiver expansion.]~~

364 ~~(b) The]Medicaid [waiver-]expansion shall:~~

365 ~~(i)~~ (a) expand Medicaid coverage to eligible individuals whose income is below [95%-]  
 366 133% of the federal poverty level;

367 ~~(ii)~~ (b) obtain maximum [federal financial participation under 42 U.S.C. Sec. 1396d(y)]

- 368 expansion FMAP for enrolling an individual in the Medicaid program;  
 369 [(iii)] (c) provide Medicaid benefits through the state's Medicaid accountable care  
 370 organizations in areas where a Medicaid accountable care organization is  
 371 implemented;  
 372 [(iv)] (d) integrate the delivery of behavioral health services and physical health services  
 373 with Medicaid accountable care organizations in select geographic areas of the state  
 374 that choose an integrated model;  
 375 [(v)] (e) include a path to self-sufficiency, including work activities as defined in 42  
 376 U.S.C. Sec. 607(d), for qualified adults;  
 377 [(vi)] (f) require an individual who is offered a private health benefit plan by an employer  
 378 to enroll in the employer's health plan;  
 379 [(vii)] (g) sunset in accordance with Subsection [(5)(a)] (4)(a);[-and]  
 380 [(viii)] (h) permit the state to close enrollment in the Medicaid waiver expansion if the  
 381 department has insufficient funding to provide services to additional eligible  
 382 individuals[-] ; and  
 383 (i) if approved by CMS:  
 384 (i) administer federal funds for Medicaid expansion according to a per capita cap  
 385 developed by the department that includes an annual inflationary adjustment,  
 386 accounts for differences in cost among categories of Medicaid expansion  
 387 enrollees, and provides greater flexibility to the state than the current Medicaid  
 388 payment model;  
 389 (ii) limit, in certain circumstances as defined by the department, the ability of a  
 390 qualified entity to determine presumptive eligibility for Medicaid coverage for an  
 391 individual enrolled in Medicaid expansion;  
 392 (iii) impose a lock-out period if an individual enrolled in Medicaid expansion violates  
 393 certain program requirements as defined by the department;  
 394 (iv) allow an individual enrolled in Medicaid expansion to remain in the Medicaid  
 395 program for up to a 12-month certification period as defined by the department;  
 396 and  
 397 (v) allow federal Medicaid funds to be used for housing support for eligible enrollees  
 398 in Medicaid expansion.  
 399 [~~(3) If the Medicaid waiver described in Subsection (2)(a) is approved, the department may~~  
 400 ~~only pay the state portion of costs for the Medicaid waiver expansion with~~  
 401 ~~appropriations from:]~~

- 402        [(a) the Medicaid ACA Fund, created in Section 26B-1-315;]
- 403        [(b) county contributions to the non-federal share of Medicaid expenditures; and]
- 404        [(c) any other contributions, funds, or transfers from a non-state agency for Medicaid
- 405                expenditures.]
- 406        [(4)] (3)(a) In consultation with the department, Medicaid accountable care organizations
- 407                and counties that elect to integrate care under Subsection [(2)(b)(iv)] (2)(d) shall
- 408                collaborate on enrollment, engagement of patients, and coordination of services.
- 409        (b) As part of the provision described in Subsection [(2)(b)(iv)] (2)(d), the department
- 410                shall apply for a waiver to permit the creation of an integrated delivery system:
- 411                (i) for any geographic area that expresses interest in integrating the delivery of
- 412                        services under Subsection [(2)(b)(iv)] (2)(d); and
- 413                (ii) in which the department:
- 414                        (A) may permit a local mental health authority to integrate the delivery of
- 415                                behavioral health services and physical health services;
- 416                        (B) may permit a county, local mental health authority, or Medicaid accountable
- 417                                care organization to integrate the delivery of behavioral health services and
- 418                                physical health services to select groups within the population that are newly
- 419                                eligible under the Medicaid waiver expansion; and
- 420                        (C) may make rules in accordance with Title 63G, Chapter 3, Utah Administrative
- 421                                Rulemaking Act, to integrate payments for behavioral health services and
- 422                                physical health services to plans or providers.
- 423        [(5)] (4)(a) If [~~federal financial participation for the Medicaid waiver expansion is~~
- 424                ~~reduced below 90%~~] the expansion FMAP rate is reduced below 90%, the authority of
- 425                the department to implement [~~the~~]Medicaid [~~waiver~~]expansion shall sunset [~~no later~~
- 426                ~~than the next July 1 after the date on which the federal financial participation is~~
- 427                ~~reduced.~~] on the day after the day the Legislature adjourns sine die from the General
- 428                Legislative Session that occurs after the date on which the expansion FMAP rate is
- 429                reduced below 90%.
- 430        (b) The department shall commence the process of terminating the Medicaid expansion
- 431                waiver and making system changes to implement the termination beginning on the
- 432                day Medicaid expansion authority sunsets under Subsection (4)(a).
- 433        (c) Notwithstanding any provision of law, if the department operates or is involved in a
- 434                discrete program that will cause the expansion FMAP rate to be reduced for adults in
- 435                the expansion population and ceasing involvement or terminating the program would

436 avoid the rate reduction, the department shall cease any involvement in or terminate  
 437 the discrete program causing the reduction before the state would experience the first  
 438 reduction in expansion FMAP rate.

439 (d)(i) Within 60 days from the day of a state determination that the expansion FMAP  
 440 rate will be reduced below 90%, the department shall create a proposal that  
 441 outlines options for how the department may maintain Medicaid expansion within  
 442 projected funding.

443 (ii) The department shall submit the proposal to the Governor's Office of Planning  
 444 and Budget, the Office of the Legislative Fiscal Analyst, the Social Services  
 445 Appropriations Subcommittee, and the Executive Appropriations Committee.

446 (iii) The department's proposal shall consider the following cost containment efforts  
 447 to the extent allowed by federal rules and regulations:

448 (A) reducing Medicaid expansion administrative costs, including suspending  
 449 hiring of noncritical employees and suspending increasing employee wages,  
 450 excluding employee benefits offered to employees state-wide;

451 (B) suspending increases to provider payment rates that would be paid for using  
 452 general funds or income tax funds;

453 (C) reversing provider payment rate increases approved or implemented during  
 454 the one-year period immediately before the day of the state determination that  
 455 the expansion FMAP rate is reduced if the rate increase is paid for using  
 456 general funds or income tax funds;

457 (D) suspending the expansion of benefits that are paid for using general funds or  
 458 income tax funds;

459 (E) eliminating coverage for optional services that are paid for using general funds  
 460 or income tax funds;

461 (F) eliminating coverage for optional populations included in Medicaid expansion;  
 462 and

463 (G) closing enrollment to new members.

464 [(b)] (e) The department shall close the program to new enrollment if the cost of [the-]  
 465 Medicaid [waiver-]expansion is projected to exceed the appropriations for the fiscal  
 466 year that are authorized by the Legislature through an appropriations act adopted in  
 467 accordance with Title 63J, Chapter 1, Budgetary Procedures Act.

468 (f) If the authority for Medicaid expansion sunsets, not more than 90 days after the day  
 469 the authority sunsets, the department and the Governor's Office of Planning and

470 Budget shall provide recommendations to the Executive Appropriations Committee  
471 regarding how any remaining funds in the Medicaid ACA Fund, created in Section  
472 26B-1-315, should be used.

473 Section 5. Section **26B-3-506** is amended to read:

474 **26B-3-506 (Effective 05/06/26) (Repealed 07/01/34). Hospital financing of health**  
475 **coverage improvement program Medicaid waiver expansion -- Hospital share.**

476 (1) The hospital share is:

- 477 (a) 45% of the state's net cost of the health coverage improvement program, including  
478 Medicaid coverage for individuals with dependent children up to the federal poverty  
479 level designated under Section 26B-3-207;
- 480 (b) 45% of the state's net cost of the enhancement waiver program;
- 481 (c) if the waiver for the Medicaid waiver expansion is approved, \$11,900,000; and
- 482 (d) 45% of the state's net cost of the upper payment limit gap.

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

- 484 (i) an \$11,900,000 cap for the programs specified in Subsections (1)(a) through (c);  
485 and  
486 (ii) a \$1,700,000 cap for the program specified in Subsection (1)(d).

487 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in  
488 which the programs specified in Subsections (1)(a) and (d) are not in effect for the  
489 full fiscal year.

490 (3) Private hospitals shall be assessed under this part for:

- 491 (a) 69% of the portion of the hospital share for the programs specified in Subsections  
492 (1)(a) through (c); and  
493 (b) 100% of the portion of the hospital share specified in Subsection (1)(d).

494 (4)(a) In the report described in Subsection [~~26B-3-113(8)~~] 26B-3-113(6), the department  
495 shall calculate the state's net cost of each of the programs described in Subsections  
496 (1)(a) through (c) that are in effect for that year.

497 (b) If the assessment collected in the previous fiscal year is above or below the hospital  
498 share for private hospitals for the previous fiscal year, the underpayment or  
499 overpayment of the assessment by the private hospitals shall be applied to the fiscal  
500 year in which the report is issued.

501 (5) A Medicaid accountable care organization shall, on or before October 15 of each year,  
502 report to the department the following data from the prior state fiscal year for each  
503 private hospital, state teaching hospital, and non-state government hospital provider that

- 504 the Medicaid accountable care organization contracts with:
- 505 (a) for the traditional Medicaid population:
- 506 (i) hospital inpatient payments;
- 507 (ii) hospital inpatient discharges;
- 508 (iii) hospital inpatient days; and
- 509 (iv) hospital outpatient payments; and
- 510 (b) if the Medicaid accountable care organization enrolls any individuals in the health
- 511 coverage improvement program, the enhancement waiver program, or the Medicaid
- 512 waiver expansion, for the population newly eligible for any of those programs:
- 513 (i) hospital inpatient payments;
- 514 (ii) hospital inpatient discharges;
- 515 (iii) hospital inpatient days; and
- 516 (iv) hospital outpatient payments.
- 517 (6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
- 518 Administrative Rulemaking Act, provide details surrounding specific content and format
- 519 for the reporting by the Medicaid accountable care organization.

520 Section 6. Section **26B-3-601** is amended to read:

521 **26B-3-601 (Effective 05/06/26) (Repealed 07/01/34). Definitions.**

522 As used in this part:

- 523 (1) "Assessment" means the Medicaid expansion hospital assessment established by this
- 524 part.
- 525 (2) "CMS" means the Centers for Medicare and Medicaid Services within the United States
- 526 Department of Health and Human Services.
- 527 (3) "Discharges" means the number of total hospital discharges reported on:
- 528 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost
- 529 report for the applicable assessment year; or
- 530 (b) a similar report adopted by the department by administrative rule, if the report under
- 531 Subsection (3)(a) is no longer available.
- 532 (4) "Division" means the Division of Integrated Healthcare within the department.
- 533 (5) "Hospital share" means the hospital share described in Section 26B-3-605.
- 534 (6) "Medicaid accountable care organization" means a managed care organization, as
- 535 defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of
- 536 Section 26B-3-202.
- 537 (7) "Medicaid ACA Fund" means the Medicaid ACA Fund created in Section 26B-1-315.

- 538 (8) "Medicaid waiver expansion" means the same as that term is defined in Section  
 539 26B-3-210.
- 540 (9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of  
 541 hospitals.
- 542 (10)(a) "Non-state government hospital" means a hospital owned by a non-state  
 543 government entity.
- 544 (b) "Non-state government hospital" does not include:  
 545 (i) the Utah State Hospital; or  
 546 (ii) a hospital owned by the federal government, including the Veterans  
 547 Administration Hospital.
- 548 (11)(a) "Private hospital" means:  
 549 (i) a privately owned general acute hospital operating in the state as defined in  
 550 Section 26B-2-201; or  
 551 (ii) a privately owned specialty hospital operating in the state, including a privately  
 552 owned hospital for which inpatient admissions are predominantly:  
 553 (A) rehabilitation;  
 554 (B) psychiatric;  
 555 (C) chemical dependency; or  
 556 (D) long-term acute care services.
- 557 (b) "Private hospital" does not include a facility for residential treatment as defined in  
 558 Section 26B-2-101.
- 559 [~~(12) "Qualified Medicaid expansion" means an expansion of the Medicaid program in~~  
 560 ~~accordance with Subsection 26B-3-113(5).]~~
- 561 [(13)] (12) "State teaching hospital" means a state owned teaching hospital that is part of an  
 562 institution of higher education.
- 563 Section 7. Section **26B-3-606** is amended to read:  
 564 **26B-3-606 (Effective 05/06/26) (Repealed 07/01/34). Hospital financing.**
- 565 (1) Private hospitals shall be assessed under this part for the portion of the hospital share  
 566 described in Section 26B-3-611.
- 567 (2) In the report described in Subsection [~~26B-3-113(8)~~] 26B-3-113(6), the department shall  
 568 calculate the state's net cost of [~~the qualified~~] Medicaid expansion.
- 569 (3) If the assessment collected in the previous fiscal year is above or below the hospital  
 570 share for private hospitals for the previous fiscal year, the division shall apply the  
 571 underpayment or overpayment of the assessment by the private hospitals to the fiscal

572 year in which the report is issued.

573 Section 8. Section **26B-3-707** is amended to read:

574 **26B-3-707 (Effective 05/06/26) (Repealed 07/01/28). Medicaid hospital**  
575 **adjustment under Medicaid accountable care organization rates.**

576 (1) To preserve and improve access to hospital services, the division shall incorporate into  
577 the Medicaid accountable care organization rate structure calculation consistent with the  
578 certified actuarial rate range:

579 (a) \$154,000,000 to be allocated toward the hospital inpatient directed payments for the  
580 Medicaid eligibility categories covered in Utah before January 1, 2019; and

581 (b) within available funds, an amount equal to the difference between payments made to  
582 hospitals by Medicaid accountable care organizations for the Medicaid eligibility  
583 categories covered in Utah, based on submitted encounter data, and the maximum  
584 amount that could be paid for those services, to be used for directed payments to  
585 hospitals for inpatient and outpatient services.

586 (2)(a) To preserve and improve the quality of inpatient and outpatient hospital services  
587 authorized under Subsection (1)(b), the division shall amend its quality strategies  
588 required by 42 C.F.R. Sec. 438.340 to include quality measures selected from the  
589 CMS hospital quality improvement programs.

590 (b) To better address the unique needs of rural and specialty hospitals, the division may  
591 adopt different quality standards for rural and specialty hospitals.

592 (c) The division shall make rules in accordance with Title 63G, Chapter 3, Utah  
593 Administrative Rulemaking Act, to adopt the selected quality measures and prescribe  
594 penalties for not meeting the quality standards that are established by the division by  
595 rule.

596 (d) The division shall apply the same quality measures and penalties under this  
597 Subsection (2) to new directed payments made to the University of Utah Hospital and  
598 Clinics.

599 Section 9. **Effective Date.**

600 This bill takes effect on May 6, 2026.