HB0015S02 compared with HB0015S01

~~{Omitted text}~~ shows text that was in HB0015S01 but was omitted in HB0015S02
inserted text shows text that was not in HB0015S01 but was inserted into HB0015S02

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.

Medicaid Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Steve Eliason

Senate Sponsor:Keith Grover

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

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

26B-3-506 (Effective 05/06/26) (Repealed 07/01/34), as renumbered and amended by Laws of Utah 2023, Chapter 306

26B-3-601 (Effective 05/06/26) (Repealed 07/01/34), as last amended by Laws of Utah 2024, Chapter 439

26B-3-606 (Effective 05/06/26) (Repealed 07/01/34), as renumbered and amended by Laws of Utah 2023, Chapter 306

26B-3-707 (Effective 05/06/26) (Repealed 07/01/28), as last amended by Laws of Utah 2024, Chapter 284

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

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

26B-3-109. 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. Sec. 1315 from the secretary of the United States Department of Health and Human Services.

(4) The Medicaid program shall provide for eligibility for [~~persons as required by Subsection 26B-3-113(2)~~] individuals authorized to be enrolled in Medicaid under Sections 26B-3-113 and 26B-3-210.

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

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

26B-3-113. Expanding the Medicaid program.

(1) As used in this section:

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

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

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

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

[~~(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 26B-3-210.~~]

[~~(c) The department may implement any provision described in Subsections 26B-3-210(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 ACA 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 ACA 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, 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)~~] (3)

[~~(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 26B-3-127 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 PPACA 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 26B-3-210(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 26B-3-207.~~]

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

(i) the Medicaid ACA 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)~~] (b) If the costs of the Medicaid expansion [~~under this Subsection (5)~~]exceed the funds available under Subsection [~~(5)(e)~~] (3)(a):

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

(ii) savings, as determined by the department, from the reduction or elimination of optional Medicaid services under Subsection [~~(5)(f)(i)~~] (3)(b)(i) shall be deposited into the Medicaid ACA 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)~~] (c) 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)~~] (3)(a), including savings resulting from any action taken under Subsection [~~(5)(f)~~] (3)(b):

(i) the governor shall direct the department 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 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)~~] (3)(c)(ii) into the Medicaid ACA Fund.

[~~(6)~~] (4) The department shall maximize federal financial participation in implementing this section, including by seeking to obtain any necessary federal approvals or waivers.

[~~(7)~~] (5) Notwithstanding Sections 17-77-201 and 17-77-301, 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)~~] (6) 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 26B-3-506(4) and 26B-3-606(2), the state's net cost of the [~~qualified~~]Medicaid expansion.

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

26B-3-207. Health coverage improvement program -- Eligibility -- Annual report -- Expansion of eligibility for adults with dependent children.

(1) As used in this section:

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

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

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

(b) "Enhancement waiver program" means the Primary Care Network enhancement waiver program described in Section 26B-3-211.

(c) "Federal poverty level" means the poverty guidelines established by the Secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).

(d) "Health coverage improvement program" means the health coverage improvement program described in Subsections (3) through (9).

(e) "Homeless":

(i) means an individual who is chronically homeless, as determined by the department; and

(ii) includes someone who was chronically homeless and is currently living in supported housing for the chronically homeless.

(f) "Income eligibility ceiling" means the percent of federal poverty level:

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

(ii) under which an individual may qualify for Medicaid coverage in accordance with this section.

(g) "Targeted adult Medicaid program" means the program implemented by the department under Subsections (5) through (7).

(2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to allow temporary residential treatment for substance use, for the traditional Medicaid population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that provides rehabilitation services that

are medically necessary and in accordance with an individualized treatment plan, as approved by CMS and as long as the county makes the required match under Section 17-77-201.

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

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

(5)

(a) An adult in the expansion population is eligible for Medicaid if the adult meets the income eligibility and other criteria established under Subsection (6).

(b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:

(i) through the traditional fee for service Medicaid model in counties without Medicaid accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented and subject to Section 26B-3-223;

(ii) except as provided in Subsection (5)(b)(iii), for behavioral health, through the counties in accordance with Sections 17-77-201 and 17-77-301;

(iii) that, subject to Section 26B-3-223, integrates behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model; and

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

(6)

(a) An individual is eligible for the health coverage improvement program under Subsection (5) if:

(i) at the time of enrollment, the individual's annual income is below the income eligibility ceiling established by the state under Subsection (1)(f); and

(ii) the individual meets the eligibility criteria established by the department under Subsection (6)(b).

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

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

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

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

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

(c) [~~An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b) may remain on the Medicaid program for a 12-month certification period as defined by the department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall not apply to an individual during the 12-month certification period.~~] {~~If~~ } Subject to Subsection (6)(d), if approved by CMS:

(i) an individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b) may remain on the Medicaid program for a {~~six-month~~ } certification period {~~as defined by the department~~} not to exceed 12 months; and

(ii) eligibility changes made by the department under Subsection (1)(f) or (6)(b) do not apply to an individual during the {~~six-month~~ } certification period.

{~~(d) {Before January 1, 2027, the department shall seek approval from CMS to implement Subsection (6)(c).}~~ }

(d)

{~~(7)~~} The department may not seek approval from CMS to implement Subsection (6)(c) unless the executive director determines that CMS is likely to approve a waiver described in Subsection (6)(c).

(ii) If the executive director determines CMS is likely to approve a waiver described in Subsection (6)(c), the department shall apply for the waiver within 120 days of the determination.

(iii) When applying for the waiver, the department may alter the length of the certification period described in Subsection (6)(c)(i) as necessary to obtain the waiver if the length of the certification period does not exceed 12 months.

(7) The state may request a modification of the income eligibility ceiling and other eligibility criteria under Subsection (6) each fiscal year based on projected enrollment, costs to the state, and the state budget.

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

(9) Notwithstanding Sections 17-77-201 and 17-77-301, a county does not have to provide matching funds to the state for the cost of providing Medicaid services to newly enrolled individuals who qualify for Medicaid coverage under the health coverage improvement program under Subsection (6).

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

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

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

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

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

(e) shall work with CMS to maintain any waiver for the health coverage improvement program while the health coverage improvement program is suspended under Subsection (10)(c).

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

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

26B-3-210. Medicaid expansion.

(1) As used in this section:

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

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

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

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

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

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

{~~(c) {"Effective expansion FMAP" means the amount that equals:}~~ }

{~~(i) {federal payments divided by the sum of federal payments and state expenditures; and}~~ }

{~~(ii) {multiplied by 100.}~~ }

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

(e){(d) {~~"Federal payments" means payments made, or projected to be made, by the federal government to pay for services for each adult in the expansion population not including administrative costs.~~}

{~~(f)~~} "Federal poverty level" means the same as that term is defined in Section 26B-3-207.

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

{~~(h) "State expenditures" means the amount of state expenditures made, or projected to be made, by the Medicaid program to pay for services provided to each adult in the expansion population not including administrative costs.~~}

(2)

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

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

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

[~~(ii)~~] (b) obtain maximum [~~federal financial participation under 42 U.S.C. Sec. 1396d(y)~~] expansion FMAP for enrolling an individual in the Medicaid program;

[~~(iii)~~] (c) provide Medicaid benefits through the state's Medicaid accountable care organizations in areas where a Medicaid accountable care organization is implemented;

[~~(iv)~~] (d) integrate the delivery of behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model;

[~~(v)~~] (e) include a path to self-sufficiency, including work activities as defined in 42 U.S.C. Sec. 607(d), for qualified adults;

[~~(vi)~~] (f) require an individual who is offered a private health benefit plan by an employer to enroll in the employer's health plan;

[~~(vii)~~] (g) sunset in accordance with Subsection [~~(5)(a)~~] (4)(a);[~~ and~~]

[~~(viii)~~] (h) permit the state to close enrollment in the Medicaid waiver expansion if the department has insufficient funding to provide services to additional eligible individuals[~~.~~] ; and

(i) if approved by CMS:

(i) administer federal funds for Medicaid expansion 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, the ability of a qualified entity to determine presumptive eligibility for Medicaid coverage for an individual enrolled in Medicaid expansion;

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

(iv) allow an individual enrolled in Medicaid expansion 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 Medicaid expansion.

[~~(3) If the Medicaid waiver described in Subsection (2)(a) is approved, the department may only pay the state portion of costs for the Medicaid waiver expansion with appropriations from:~~]

[~~(a) the Medicaid ACA Fund, created in Section 26B-1-315;~~]

[~~(b) county contributions to the non-federal share of Medicaid expenditures; and~~]

[~~(c) any other contributions, funds, or transfers from a non-state agency for Medicaid expenditures.~~]

[~~(4)~~] (3)

(a) In consultation with the department, Medicaid accountable care organizations and counties that elect to integrate care under Subsection [~~(2)(b)(iv)~~] (2)(d) shall collaborate on enrollment, engagement of patients, and coordination of services.

(b) As part of the provision described in Subsection [~~(2)(b)(iv)~~] (2)(d), the department shall apply for a waiver to permit the creation of an integrated delivery system:

(i) for any geographic area that expresses interest in integrating the delivery of services under Subsection [~~(2)(b)(iv)~~] (2)(d); and

(ii) in which the department:

(A) may permit a local mental health authority to integrate the delivery of behavioral health services and physical health services;

(B) may permit a county, local mental health authority, or Medicaid accountable care organization to integrate the delivery of behavioral health services and physical health services to select groups within the population that are newly eligible under the Medicaid waiver expansion; and

(C) may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to integrate payments for behavioral health services and physical health services to plans or providers.

[~~(5)~~] (4)

(a) If [~~federal financial participation for the Medicaid waiver expansion is reduced below 90%~~] the {~~effective~~ } expansion FMAP rate is reduced below 90%, the authority of the department to implement [~~the~~]Medicaid [~~waiver~~]expansion shall sunset [~~no later than the next July 1 after the date on which the federal financial participation is reduced.~~] on{~~:~~} the day after the day the Legislature adjourns sine die from the General Legislative Session that occurs after the date on which the expansion FMAP rate is reduced below 90%.

{~~(i) {if the state first experiences the effective expansion FMAP rate reduction on or between July 1 to December 31, the following July 1; or}~~ }

(ii){~~(b)~~} {~~if the state first experiences~~ } The department shall commence the process of terminating the {~~effective~~ } Medicaid expansion {~~FMAP rate reduction on or between January 1~~ } waiver and making system changes to {~~June 30, the July 1 of the calendar year that follows~~ } implement the {~~year the state experiences~~ } termination beginning on the {~~effective~~ } day Medicaid expansion {~~FMAP reduction~~} authority sunsets under Subsection (4)(a).

{~~(b) {The calculation of the effective expansion FMAP rate:}~~ }

{~~(i) {shall be conducted jointly between the department, the Governor's Office of Planning and Budget, and the Office of the Legislative Fiscal Analyst; and}~~ }

{~~(ii) {may be calculated at any time.}~~ }

(c) Notwithstanding any provision of law, if the department operates or is involved in a discrete program that will cause the {~~effective~~ } expansion FMAP rate to be reduced for adults in the expansion population and ceasing involvement or terminating the program would avoid the rate reduction, the department shall cease any involvement in or terminate the discrete program causing the reduction before the state would experience the first reduction in {~~effective~~ } expansion FMAP rate.

(d)

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

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

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

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

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

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

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

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

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

(G) closing enrollment to new members.

[~~(b)~~] (e) The department shall close the program to new enrollment if the cost of [~~the~~]Medicaid [~~waiver~~]expansion is projected to 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.

(f) If the authority for Medicaid expansion sunsets, {~~no~~ } not more than 90 days after the day the authority sunsets, the department and the {~~Division~~ } Governor's Office of {~~Finance~~ } Planning and Budget shall provide recommendations to the Executive Appropriations Committee regarding how any remaining funds in the Medicaid ACA Fund, created in Section 26B-1-315, should be used.

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

26B-3-506. Hospital financing of health coverage improvement program Medicaid waiver expansion -- Hospital share.

(1) The hospital share is:

(a) 45% of the state's net cost of the health coverage improvement program, including Medicaid coverage for individuals with dependent children up to the federal poverty level designated under Section 26B-3-207;

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

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

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

(2)

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

(i) an $11,900,000 cap for the programs specified in Subsections (1)(a) through (c); and

(ii) a $1,700,000 cap for the program specified in Subsection (1)(d).

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

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

(a) 69% of the portion of the hospital share for the programs specified in Subsections (1)(a) through (c); and

(b) 100% of the portion of the hospital share specified in Subsection (1)(d).

(4)

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

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

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

(a) for the traditional Medicaid population:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments; and

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

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

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

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

26B-3-601. Definitions.

As used in this part:

(1) "Assessment" means the Medicaid expansion hospital assessment established by this part.

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

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

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

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

(4) "Division" means the Division of Integrated Healthcare within the department.

(5) "Hospital share" means the hospital share described in Section 26B-3-605.

(6) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26B-3-202.

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

(8) "Medicaid waiver expansion" means the same as that term is defined in Section 26B-3-210.

(9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

(10)

(a) "Non-state government hospital" means a hospital owned by a non-state government entity.

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

(i) the Utah State Hospital; or

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

(11)

(a) "Private hospital" means:

(i) a privately owned general acute hospital operating in the state as defined in Section 26B-2-201; or

(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital for which inpatient admissions are predominantly:

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services.

(b) "Private hospital" does not include a facility for residential treatment as defined in Section 26B-2-101.

[~~(12) "Qualified Medicaid expansion" means an expansion of the Medicaid program in accordance with Subsection 26B-3-113(5).~~]

[~~(13)~~] (12) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

Section 7. Section **26B-3-606** is amended to read:

26B-3-606. Hospital financing.

(1) Private hospitals shall be assessed under this part for the portion of the hospital share described in Section 26B-3-611.

(2) In the report described in Subsection [~~26B-3-113(8)~~] 26B-3-113(6), the department shall calculate the state's net cost of [~~the qualified~~]Medicaid expansion.

(3) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the division shall apply the underpayment or overpayment of the assessment by the private hospitals to the fiscal year in which the report is issued.

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

26B-3-707. Medicaid hospital adjustment under Medicaid accountable care organization rates.

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

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

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

(2)

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

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

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

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

Section 9. **Effective date.**

Effective Date.

This bill takes effect on May 6, 2026.

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