Keven J. Stratton proposes the following substitute bill:

Medicaid Provider Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Keven J. Stratton

House Sponsor:

LONG TITLE

General Description:

This bill addresses provisions related to Medicaid providers.

Highlighted Provisions:

This bill:

- permits interest earned on funds in the Medicaid ACA Fund to be appropriated for incentive payments Medicaid providers in certain circumstances;
- amends permitted uses of funds in the Medicaid ACA Fund in certain circumstances;
- requires the Department of Health and Human Services (department) to:
  - establish quality measures for evaluating Medicaid providers' performance;
  - evaluate Medicaid providers on performance as measured by the quality measures; and
  - annually report to the Social Services Appropriations Subcommittee on the performance based on the quality measures of the Medicaid providers determined by the Legislature;
- requires the department to implement a closed loop referral system for referrals for the delivery of health-related social needs care to Medicaid-eligible individuals;
- requires the Division of Services for People with Disabilities (division) to notify a provider of amendments to the provider's contract with the division;
- defines terms; and
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

1st Sub. S.B. 288

26B-1-315 (Effective 05/06/26) (Superseded 07/01/26), as last amended by Laws of Utah 2025, Chapter 135

26B-1-315 (Effective 07/01/26) (Repealed 07/01/34), as last amended by Laws of Utah 2025, Chapter 285

26B-6-403 (Effective 05/06/26), as renumbered and amended by Laws of Utah 2023, Chapter 308

ENACTS:

26B-3-143 (Effective 05/06/26), Utah Code Annotated 1953

26B-3-144 (Effective 05/06/26), Utah Code Annotated 1953

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

Section 1. Section **26B-1-315** is amended to read:

26B-1-315 (Effective 05/06/26) (Superseded 07/01/26). Medicaid ACA Fund.

(1) There is created an expendable special revenue fund known as the "Medicaid ACA Fund."

(2) The fund consists of:

(a) assessments collected under Chapter 3, Part 5, Inpatient Hospital Assessment;

(b) intergovernmental transfers under Section 26B-3-508;

(c) savings attributable to the health coverage improvement program, as defined in Section 26B-3-501, as determined by the department;

(d) savings attributable to the enhancement waiver program, as defined in Section 26B-3-501, as determined by the department;

(e) savings attributable to the Medicaid waiver expansion, as defined in Section 26B-3-501, as determined by the department;

(f) revenues collected from the sales tax described in Subsection 59-12-103(11);

(g) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;

(h) interest earned on money in the fund; and

(i) additional amounts as appropriated by the Legislature.

(3)(a) The fund shall earn interest.

(b) All interest earned on fund money shall be deposited into the fund.

(c) The Legislature may appropriate interest earned on fund money for the purposes described in Subsection (4)(a)(v)(A).

(4)(a) A state agency administering the provisions of Chapter 3, Part 5, Inpatient

Hospital Assessment, may use money from the fund to pay the costs, not otherwise paid for with federal funds or other revenue sources, of:

(i) the health coverage improvement program as defined in Section 26B-3-501;

(ii) the enhancement waiver program as defined in Section 26B-3-501;

(iii) a Medicaid waiver expansion as defined in Section 26B-3-501; [~~and~~]

(iv) the outpatient upper payment limit supplemental payments under Section 26B-3-511[~~.~~] ; and

(v) if money remains in the fund after money from the fund has been used for the purposes described in Subsections (4)(a)(i) through (iv):

(A) within appropriations from the Legislature for this purpose as described in Subsection (3)(c), incentive payments and related administrative costs as described in Section 26B-3-143; and

(B) the closed loop referral system described in Section 26B-3-144.

(b) A state agency administering the provisions of Chapter 3, Part 5, Inpatient Hospital Assessment, may not use:

(i) funds described in Subsection (2)(b) to pay the cost of private outpatient upper payment limit supplemental payments; or

(ii) money in the fund for any purpose not described in Subsection (4)(a).

Section 2. Section **26B-1-315** is amended to read:

26B-1-315 (Effective 07/01/26) (Repealed 07/01/34). Medicaid ACA Fund.

(1) There is created an expendable special revenue fund known as the "Medicaid ACA Fund."

(2) The fund consists of:

(a) assessments collected under Chapter 3, Part 5, Inpatient Hospital Assessment;

(b) intergovernmental transfers under Section 26B-3-508;

(c) savings attributable to the health coverage improvement program, as defined in Section 26B-3-501, as determined by the department;

(d) savings attributable to the enhancement waiver program, as defined in Section 26B-3-501, as determined by the department;

(e) savings attributable to the Medicaid waiver expansion, as defined in Section 26B-3-501, as determined by the department;

(f) revenues collected from the sales tax described in Subsection 59-12-103(6);

(g) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;

(h) interest earned on money in the fund; and

(i) additional amounts as appropriated by the Legislature.

(3)(a) The fund shall earn interest.

(b) All interest earned on fund money shall be deposited into the fund.

(c) The Legislature may appropriate interest earned on fund money for the purposes described in Subsection (4)(a)(v)(A).

(4)(a) A state agency administering the provisions of Chapter 3, Part 5, Inpatient Hospital Assessment, may use money from the fund to pay the costs, not otherwise paid for with federal funds or other revenue sources, of:

(i) the health coverage improvement program as defined in Section 26B-3-501;

(ii) the enhancement waiver program as defined in Section 26B-3-501;

(iii) a Medicaid waiver expansion as defined in Section 26B-3-501; [~~and~~]

(iv) the outpatient upper payment limit supplemental payments under Section 26B-3-511[~~.~~] ; and

(v) if money remains in the fund after money from the fund has been used for the purposes described in Subsections (4)(a)(i) through (iv):

(A) within appropriations from the Legislature for this purpose as described in Subsection (3)(c), incentive payments and related administrative costs as described in Section 26B-3-143; and

(B) the closed loop referral system described in Section 26B-3-144.

(b) A state agency administering the provisions of Chapter 3, Part 5, Inpatient Hospital Assessment, may not use:

(i) funds described in Subsection (2)(b) to pay the cost of private outpatient upper payment limit supplemental payments; or

(ii) money in the fund for any purpose not described in Subsection (4)(a).

Section 3. Section **26B-3-143** is enacted to read:

26B-3-143 (Effective 05/06/26). Medicaid provider quality measures -- Reporting -- Eligibility for incentive payments.

(1) As used in this section:

(a) "Incentive payment" means a fee-for-services payment to a participating Medicaid provider, including a managed care entity or a Medicaid provider that is paid under a fee-for-service arrangement, based on the Medicaid provider's performance as evaluated by the department as described in this section.

(b) "Managed care entity" means a person that contracts with the Medicaid program to

manage the provision of health care services in a managed care delivery system on a capitated basis.

(c) "Medicaid provider" means any person, individual, corporation, institution, or organization that:

(i) is currently enrolled in the Medicaid program;

(ii) provides Medicaid-covered services under the Medicaid program;

(iii) has entered into a provider agreement with the Medicaid program; and

(iv) is reimbursed:

(A) through a managed care entity; or

(B) fee-for-service.

(d) "Participating Medicaid provider" means a Medicaid provider:

(i) that is in a group of Medicaid providers selected by the Legislature and that the Legislature directs the department to evaluate in a fiscal year as described in Subsection (5)(a); and

(ii) that submits verifying documentation of the Medicaid provider's completion or progress toward quality measures in accordance with rules made by the department under this section.

(e) "Quality measures" means the metrics the department establishes to evaluate a Medicaid provider's performance as described in Subsection (2).

(2)(a) The department shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish quality measures.

(b) Quality measures may include:

(i) improved health outcomes and care experience for enrollees;

(ii) care coordination, data sharing, and value-based delivery;

(iii) workforce stability and evidence-based clinical practices; and

(iv) any other metrics or performance areas the department deems appropriate.

(c) The department shall establish separate quality measures for each Medicaid provider type selected for participation in accordance with the process described in Subsections (4) and (5).

(3) The department shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish:

(a) a process for a participating Medicaid provider to submit documentation verifying the participating Medicaid provider's completion or progress toward the quality measures established for the Medicaid provider's provider type;

(b) a methodology for evaluating a participating Medicaid provider's progress toward quality measures; and

(c) exclusions for a Medicaid provider's participation based on adverse findings or disciplinary actions by a certifying, licensing, or accrediting entity.

(4)(a) The department shall annually, before October 31, submit a report to the Social Services Appropriations Subcommittee of the department's evaluation of:

(i) Medicaid provider types to assist the Legislature in selecting and prioritizing Medicaid providers eligible for incentive payments under Subsection (6) in the following fiscal year; and

(ii) participating Medicaid providers' completion or progress toward quality measures as described in Subsection (3)(b), if any.

(b) The report described in Subsection (4)(a)(i) shall include:

(i) a comparative analysis of current Medicaid reimbursement rates and rates paid by other comparable payers, including Medicare, where applicable;

(ii) the length of time since the last rate increase for the Medicaid provider type; and

(iii) an analysis of the impact of inventive payments on the Medicaid provider type.

(5)(a) Subject to appropriations from the Legislature for this purpose, and the Legislature's determination of eligible Medicaid provider types for the following fiscal year, a participating Medicaid provider may be eligible for incentive payments based on the participating Medicaid provider's performance as evaluated by the department as described in Subsection (3)(b).

(b) The department may use up to 2% of an appropriation under this section for costs related to the administration of the provisions of this section.

(6) The department shall ensure that incentive payments are distributed:

(a) proportionally to participating Medicaid providers;

(b) in accordance with legislative appropriations; and

(c) in accordance with CMS rules and regulations.

(7) The department may apply for necessary CMS authority to implement this section.

Section 4. Section **26B-3-144** is enacted to read:

26B-3-144 (Effective 05/06/26). Closed loop referral system.

(1) As used in this section:

(a) "Authorized user" means a social needs care provider authorized by rules the department makes to use a closed loop referral system.

(b) "Closed loop referral system" means a system that enables efficient outreach,

engagement, and care coordination across cross-sector social needs care providers.

(c) "Social needs care" means community-level services and supports that address health-related social needs.

(d) "Social needs care provider" means a person that contracts with the department, directly or indirectly, to provide social needs care, including a:

(i) government entity;

(ii) healthcare organization;

(iii) community organization; or

(iv) social service organization.

(2) The department shall implement a closed loop referral system for referrals for the delivery of social care to Medicaid-eligible individuals.

(3) The department shall ensure that the closed loop referral system:

(a) notifies authorized users of social needs care requests and referrals;

(b) allows authorized users to securely access relevant information related to the social care needs of individuals the authorized user serves;

(c) allows an individual's information to be accessed only with the individual's consent and consistent with applicable privacy laws;

(d) facilitates communication between referring social needs care providers using a secure chat function;

(e) sends social needs care referrals on behalf of an individual receiving social needs care; and

(f) in a single record, tracks and stores:

(i) the outcome of a referral; and

(ii) the outcome of services delivered to an individual.

(4) The department shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section, including rules to establish authorized use and authorized users of the closed loop referral system.

Section 5. Section **26B-6-403** is amended to read:

26B-6-403 (Effective 05/06/26). Responsibility and authority of division.

(1) For purposes of this section "administer" means to:

(a) plan;

(b) develop;

(c) manage;

(d) monitor; and

(e) conduct certification reviews.

(2) The division has the authority and responsibility to:

(a) administer an array of services and supports for persons with disabilities and their families throughout the state;

(b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish eligibility criteria for the services and supports described in Subsection (2)(a);

(c) consistent with Section 26B-6-506, supervise the programs and facilities of the Developmental Center;

(d) in order to enhance the quality of life for a person with a disability, establish either directly, or by contract with private, nonprofit organizations, programs of:

(i) outreach;

(ii) information and referral;

(iii) prevention;

(iv) technical assistance; and

(v) public awareness;

(e) supervise the programs and facilities operated by, or under contract with, the division;

(f) cooperate with other state, governmental, and private agencies that provide services to a person with a disability;

(g) subject to Subsection (3), ensure that a person with a disability is not deprived of that person's constitutionally protected rights without due process procedures designed to minimize the risk of error when a person with a disability is admitted to an intermediate care facility for people with an intellectual disability, including:

(i) the developmental center; and

(ii) facilities within the community;

(h) determine whether to approve providers;

(i) monitor and sanction approved providers, as specified in the providers' contract;

(j) subject to Section 26B-6-410, receive and disburse public funds;

(k) review financial actions of a provider who is a representative payee appointed by the Social Security Administration;

(l) establish standards and rules for the administration and operation of programs conducted by, or under contract with, the division;

(m) approve and monitor division programs to insure compliance with the board's rules and standards;

(n) establish standards and rules necessary to fulfill the division's responsibilities under Part 5, Utah State Developmental Center, and Part 6, Admission to an Intermediate Care Facility for People with an Intellectual Disability, with regard to an intermediate care facility for people with an intellectual disability;

(o) assess and collect equitable fees for a person who receives services provided under this chapter;

(p) maintain records of, and account for, the funds described in Subsection (2)(o);

(q) establish and apply rules to determine whether to approve, deny, or defer the division's services to a person who is:

(i) applying to receive the services; or

(ii) currently receiving the services;

(r) in accordance with state law, establish rules:

(i) relating to an intermediate care facility for people with an intellectual disability that is an endorsed program; and

(ii) governing the admission, transfer, and discharge of a person with a disability;

(s) manage funds for a person residing in a facility operated by the division:

(i) upon request of a parent or guardian of the person; or

(ii) under administrative or court order; and

(t) fulfill the responsibilities described in Section 26B-1-430.

(3) The due process procedures described in Subsection (2)(g):

(a) shall include initial and periodic reviews to determine the constitutional appropriateness of the placement; and

(b) with regard to facilities in the community, do not require commitment to the division.

(4) When the division makes amendments to a contract the division enters into under Subsection (2), the division shall notify a provider under contract with the division at least 30 days before the effective date of the amendments.

Section 6. **Effective Date.**

(1) Except as provided in Subsection (2), this bill takes effect May 6, 2026.

(2) The actions affecting Section 26B-1-315 **(Effective 07/01/26) (Repealed 07/01/34)** take effect on July 1, 2026.