HEALTH AND HUMAN SERVICES RECODIFICATION - HEALTH CARE ASSISTANCE AND DATA

2023 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill recodifies portions of the Utah Health Code and Utah Human Services Code.

Highlighted Provisions:

This bill:

- recodifies provisions regarding:
  - health care administration and assistance; and
  - vital statistics, health data, and the Utah Medical Examiner; and
- makes technical and corresponding changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26B-3-101, as enacted by Laws of Utah 2022, Chapter 255

26B-8-101, as enacted by Laws of Utah 2022, Chapter 255

RENUMBERS AND AMENDS:

26B-3-102, (Renumbered from 26-18-2.1, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-103, (Renumbered from 26-18-2.2, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-104, (Renumbered from 26-18-2.3, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-105, (Renumbered from 26-18-2.4, as last amended by Laws of Utah 2022, Chapter 255)

26B-3-106, (Renumbered from 26-18-2.5, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-107, (Renumbered from 26-18-2.6, as last amended by Laws of Utah 2021, Chapter 234)

26B-3-108, (Renumbered from 26-18-3, as last amended by Laws of Utah 2021, Chapter 422)

26B-3-109, (Renumbered from 26-18-3.1, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-110, (Renumbered from 26-18-3.5, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-111, (Renumbered from 26-18-3.6, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-112, (Renumbered from 26-18-3.8, as last amended by Laws of Utah 2020, Sixth Special Session, Chapter 3)

26B-3-113, (Renumbered from 26-18-3.9, as last amended by Laws of Utah 2020, Fifth Special Session, Chapter 4)

26B-3-114, (Renumbered from 26-18-4, as last amended by Laws of Utah 2013, Chapter 167)

26B-3-115, (Renumbered from 26-18-5, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-116, (Renumbered from 26-18-5.5, as enacted by Laws of Utah 2022, Chapter 469)

26B-3-117, (Renumbered from 26-18-6, as enacted by Laws of Utah 1981, Chapter 126)

26B-3-118, (Renumbered from 26-18-7, as last amended by Laws of Utah 1988, Chapter 21)

26B-3-119, (Renumbered from 26-18-8, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-120, (Renumbered from 26-18-9, as enacted by Laws of Utah 1981, Chapter 126)

26B-3-121, (Renumbered from 26-18-11, as last amended by Laws of Utah 2019,

Chapter 393)

26B-3-122, (Renumbered from 26-18-13, as last amended by Laws of Utah 2017, Chapter 241)

26B-3-123, (Renumbered from 26-18-13.5, as last amended by Laws of Utah 2019, Chapter 249)

26B-3-124, (Renumbered from 26-18-15, as last amended by Laws of Utah 2021, Chapter 163)

26B-3-125, (Renumbered from 26-18-16, as enacted by Laws of Utah 2012, Chapter 155)

26B-3-126, (Renumbered from 26-18-17, as enacted by Laws of Utah 2013, Chapter 53)

26B-3-127, (Renumbered from 26-18-18, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-128, (Renumbered from 26-18-19, as last amended by Laws of Utah 2016, Chapter 114)

26B-3-129, (Renumbered from 26-18-20, as last amended by Laws of Utah 2022, Chapter 443)

26B-3-130, (Renumbered from 26-18-21, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-131, (Renumbered from 26-18-22, as enacted by Laws of Utah 2017, Chapter 180)

26B-3-132, (Renumbered from 26-18-23, as enacted by Laws of Utah 2017, Chapter 53)

26B-3-133, (Renumbered from 26-18-24, as enacted by Laws of Utah 2018, Chapter 180)

26B-3-134, (Renumbered from 26-18-25, as enacted by Laws of Utah 2019, Chapter 320)

26B-3-135, (Renumbered from 26-18-26, as enacted by Laws of Utah 2019, Chapter 265)

26B-3-136, (Renumbered from 26-18-27, as enacted by Laws of Utah 2021, Chapter

163)

26B-3-137, (Renumbered from 26-18-28, as enacted by Laws of Utah 2022, Chapter 206)

26B-3-138, (Renumbered from 26-18-427, as enacted by Laws of Utah 2022, Chapter 394)

26B-3-139, (Renumbered from 26-18-603, as last amended by Laws of Utah 2015, Chapter 135)

26B-3-140, (Renumbered from 26-18-604, as last amended by Laws of Utah 2015, Chapter 135)

26B-3-141, (Renumbered from 26-18-703, as renumbered and amended by Laws of Utah 2022, Chapter 334)

26B-3-201, (Renumbered from 26-18-403, as enacted by Laws of Utah 2006, Chapter 110)

26B-3-202, (Renumbered from 26-18-405, as last amended by Laws of Utah 2020, Chapter 275)

26B-3-203, (Renumbered from 26-18-405.5, as last amended by Laws of Utah 2022, Chapter 149)

26B-3-204, (Renumbered from 26-18-408, as last amended by Laws of Utah 2020, Fifth Special Session, Chapter 4)

26B-3-205, (Renumbered from 26-18-409, as enacted by Laws of Utah 2014, Chapter 174)

26B-3-206, (Renumbered from 26-18-410, as last amended by Laws of Utah 2022, Chapter 226)

26B-3-207, (Renumbered from 26-18-411, as last amended by Laws of Utah 2022, Chapter 394)

26B-3-208, (Renumbered from 26-18-413, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-209, (Renumbered from 26-18-414, as enacted by Laws of Utah 2017, Chapter 307)

26B-3-210, (Renumbered from 26-18-415, as last amended by Laws of Utah 2019, Chapters 1 and 393)

26B-3-211, (Renumbered from 26-18-416, as last amended by Laws of Utah 2020, Chapter 354)

26B-3-212, (Renumbered from 26-18-417, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-213, (Renumbered from 26-18-418, as last amended by Laws of Utah 2020, Chapter 303)

26B-3-214, (Renumbered from 26-18-419, as enacted by Laws of Utah 2019, Chapter 172)

26B-3-215, (Renumbered from 26-18-420, as enacted by Laws of Utah 2020, Chapter 187)

26B-3-216, (Renumbered from 26-18-420.1, as enacted by Laws of Utah 2021, Chapter 133)

26B-3-217, (Renumbered from 26-18-421, as enacted by Laws of Utah 2020, Chapter 159)

26B-3-218, (Renumbered from 26-18-422, as enacted by Laws of Utah 2020, Chapter 188)

26B-3-219, (Renumbered from 26-18-423, as enacted by Laws of Utah 2020, Chapter 303)

26B-3-220, (Renumbered from 26-18-424, as enacted by Laws of Utah 2021, Chapter 76)

26B-3-221, (Renumbered from 26-18-425, as enacted by Laws of Utah 2021, Chapter 27)

26B-3-222, (Renumbered from 26-18-426, as enacted by Laws of Utah 2021, Chapter 212)

26B-3-223, (Renumbered from 26-18-428, as enacted by Laws of Utah 2022, Chapter 394)

26B-3-224, (Renumbered from 26-18-429, as enacted by Laws of Utah 2022, Chapter 253)

26B-3-301, (Renumbered from 26-18-101, as last amended by Laws of Utah 2004, Chapter 280)

26B-3-302, (Renumbered from 26-18-102, as last amended by Laws of Utah 2010, Chapters 286 and 324)

26B-3-303, (Renumbered from 26-18-103, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-304, (Renumbered from 26-18-104, as last amended by Laws of Utah 2008, Chapter 382)

26B-3-305, (Renumbered from 26-18-105, as last amended by Laws of Utah 2010, Chapter 205)

26B-3-306, (Renumbered from 26-18-106, as enacted by Laws of Utah 1992, Chapter 273)

26B-3-307, (Renumbered from 26-18-107, as last amended by Laws of Utah 2019, Chapter 349)

26B-3-308, (Renumbered from 26-18-108, as enacted by Laws of Utah 1992, Chapter 273)

26B-3-309, (Renumbered from 26-18-109, as enacted by Laws of Utah 1992, Chapter 273)

26B-3-310, (Renumbered from 26-18-502, as last amended by Laws of Utah 2021, Chapter 274)

26B-3-311, (Renumbered from 26-18-503, as last amended by Laws of Utah 2022, Chapter 274)

26B-3-312, (Renumbered from 26-18-504, as last amended by Laws of Utah 2017, Chapter 443)

26B-3-313, (Renumbered from 26-18-505, as last amended by Laws of Utah 2017, Chapter 443)

26B-3-401, (Renumbered from 26-35a-103, as last amended by Laws of Utah 2018, Chapter 39)

26B-3-402, (Renumbered from 26-35a-102, as last amended by Laws of Utah 2011, Chapter 366)

26B-3-403, (Renumbered from 26-35a-104, as last amended by Laws of Utah 2017, Chapter 443)

26B-3-404, (Renumbered from 26-35a-105, as enacted by Laws of Utah 2004, Chapter

284)

26B-3-405, (Renumbered from 26-35a-106, as last amended by Laws of Utah 2017, Chapter 443)

26B-3-406, (Renumbered from 26-35a-107, as last amended by Laws of Utah 2017, Chapter 443)

26B-3-407, (Renumbered from 26-35a-108, as last amended by Laws of Utah 2011, Chapter 366)

26B-3-501, (Renumbered from 26-36b-103, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-502, (Renumbered from 26-36b-102, as last amended by Laws of Utah 2018, Chapter 384)

26B-3-503, (Renumbered from 26-36b-201, as last amended by Laws of Utah 2018, Chapters 384 and 468)

26B-3-504, (Renumbered from 26-36b-202, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-505, (Renumbered from 26-36b-203, as last amended by Laws of Utah 2018, Chapters 384 and 468)

26B-3-506, (Renumbered from 26-36b-204, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-507, (Renumbered from 26-36b-205, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-508, (Renumbered from 26-36b-206, as last amended by Laws of Utah 2018, Chapters 384 and 468)

26B-3-509, (Renumbered from 26-36b-207, as last amended by Laws of Utah 2018, Chapters 384 and 468)

26B-3-510, (Renumbered from 26-36b-209, as last amended by Laws of Utah 2018, Chapters 384 and 468)

26B-3-511, (Renumbered from 26-36b-210, as last amended by Laws of Utah 2018, Chapters 384 and 468)

26B-3-512, (Renumbered from 26-36b-211, as last amended by Laws of Utah 2018,

Chapters 384 and 468)

26B-3-601, (Renumbered from 26-36c-102, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-602, (Renumbered from 26-36c-103, as enacted by Laws of Utah 2018, Chapter 468)

26B-3-603, (Renumbered from 26-36c-201, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-604, (Renumbered from 26-36c-202, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-605, (Renumbered from 26-36c-203, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-606, (Renumbered from 26-36c-204, as last amended by Laws of Utah 2020, Chapter 225)

26B-3-607, (Renumbered from 26-36c-205, as last amended by Laws of Utah 2019, Chapter 136)

26B-3-608, (Renumbered from 26-36c-206, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-609, (Renumbered from 26-36c-207, as enacted by Laws of Utah 2018, Chapter 468)

26B-3-610, (Renumbered from 26-36c-208, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-611, (Renumbered from 26-36c-209, as last amended by Laws of Utah 2019, Chapter 1)

26B-3-612, (Renumbered from 26-36c-210, as last amended by Laws of Utah 2019, Chapter 136)

26B-3-701, (Renumbered from 26-36d-103, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-702, (Renumbered from 26-36d-102, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-703, (Renumbered from 26-36d-201, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-704, (Renumbered from 26-36d-202, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-705, (Renumbered from 26-36d-203, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-706, (Renumbered from 26-36d-204, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-707, (Renumbered from 26-36d-205, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-708, (Renumbered from 26-36d-206, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-709, (Renumbered from 26-36d-208, as repealed and reenacted by Laws of Utah 2019, Chapter 455)

26B-3-801, (Renumbered from 26-37a-102, as last amended by Laws of Utah 2016, Chapter 348)

26B-3-802, (Renumbered from 26-37a-103, as enacted by Laws of Utah 2015, Chapter 440)

26B-3-803, (Renumbered from 26-37a-104, as enacted by Laws of Utah 2015, Chapter 440)

26B-3-804, (Renumbered from 26-37a-105, as enacted by Laws of Utah 2015, Chapter 440)

26B-3-805, (Renumbered from 26-37a-106, as enacted by Laws of Utah 2015, Chapter 440)

26B-3-806, (Renumbered from 26-37a-108, as enacted by Laws of Utah 2015, Chapter 440)

26B-3-901, (Renumbered from 26-40-102, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-902, (Renumbered from 26-40-103, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-903, (Renumbered from 26-40-105, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-904, (Renumbered from 26-40-106, as last amended by Laws of Utah 2021, Chapter 175)

26B-3-905, (Renumbered from 26-40-107, as enacted by Laws of Utah 1998, Chapter 360)

26B-3-906, (Renumbered from 26-40-108, as last amended by Laws of Utah 2010, Chapter 391)

26B-3-907, (Renumbered from 26-40-109, as last amended by Laws of Utah 2013, Chapter 167)

26B-3-908, (Renumbered from 26-40-110, as last amended by Laws of Utah 2019, Chapter 393)

26B-3-909, (Renumbered from 26-40-115, as last amended by Laws of Utah 2020, Chapters 32 and 152)

26B-3-1001, (Renumbered from 26-19-102, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1002, (Renumbered from 26-19-103, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1003, (Renumbered from 26-19-201, as last amended by Laws of Utah 2021, Chapter 300)

26B-3-1004, (Renumbered from 26-19-301, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1005, (Renumbered from 26-19-302, as last amended by Laws of Utah 2020, Chapter 354)

26B-3-1006, (Renumbered from 26-19-303, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1007, (Renumbered from 26-19-304, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1008, (Renumbered from 26-19-305, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1009, (Renumbered from 26-19-401, as last amended by Laws of Utah 2021, Chapter 300)

26B-3-1010, (Renumbered from 26-19-402, as renumbered and amended by Laws of

Utah 2018, Chapter 443)

26B-3-1011, (Renumbered from 26-19-403, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1012, (Renumbered from 26-19-404, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1013, (Renumbered from 26-19-405, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1014, (Renumbered from 26-19-406, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1015, (Renumbered from 26-19-501, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1016, (Renumbered from 26-19-502, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1017, (Renumbered from 26-19-503, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1018, (Renumbered from 26-19-504, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1019, (Renumbered from 26-19-505, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1020, (Renumbered from 26-19-506, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1021, (Renumbered from 26-19-507, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1022, (Renumbered from 26-19-508, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1023, (Renumbered from 26-19-509, as enacted by Laws of Utah 2018, Chapter 443)

26B-3-1024, (Renumbered from 26-19-601, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1025, (Renumbered from 26-19-602, as renumbered and amended by Laws of

Utah 2018, Chapter 443)

26B-3-1026, (Renumbered from 26-19-603, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1027, (Renumbered from 26-19-604, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1028, (Renumbered from 26-19-605, as renumbered and amended by Laws of Utah 2018, Chapter 443)

26B-3-1101, (Renumbered from 26-20-2, as last amended by Laws of Utah 2007, Chapter 48)

26B-3-1102, (Renumbered from 26-20-3, as last amended by Laws of Utah 2011, Chapter 297)

26B-3-1103, (Renumbered from 26-20-4, as repealed and reenacted by Laws of Utah 2007, Chapter 48)

26B-3-1104, (Renumbered from 26-20-5, as last amended by Laws of Utah 2007, Chapter 48)

26B-3-1105, (Renumbered from 26-20-6, as last amended by Laws of Utah 2011, Chapter 297)

26B-3-1106, (Renumbered from 26-20-7, as last amended by Laws of Utah 2007, Chapter 48)

26B-3-1107, (Renumbered from 26-20-8, as last amended by Laws of Utah 2011, Chapter 297)

26B-3-1108, (Renumbered from 26-20-9, as last amended by Laws of Utah 2007, Chapter 48)

26B-3-1109, (Renumbered from 26-20-9.5, as last amended by Laws of Utah 2011, Chapter 297)

26B-3-1110, (Renumbered from 26-20-10, as last amended by Laws of Utah 1998, Chapter 192)

26B-3-1111, (Renumbered from 26-20-11, as enacted by Laws of Utah 1986, Chapter 46)

26B-3-1112, (Renumbered from 26-20-12, as last amended by Laws of Utah 2011, Chapter 297)

26B-3-1113, (Renumbered from 26-20-13, as last amended by Laws of Utah 2007, Chapter 48)

26B-3-1114, (Renumbered from 26-20-14, as last amended by Laws of Utah 2011, Chapter 297)

26B-3-1115, (Renumbered from 26-20-15, as enacted by Laws of Utah 2007, Chapter 48)

26B-8-102, (Renumbered from 26-2-3, as last amended by Laws of Utah 2017, Chapter 22)

26B-8-103, (Renumbered from 26-2-4, as last amended by Laws of Utah 2022, Chapters 231 and 365)

26B-8-104, (Renumbered from 26-2-5, as last amended by Laws of Utah 2019, Chapter 349)

26B-8-105, (Renumbered from 26-2-5.5, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-106, (Renumbered from 26-2-6, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-107, (Renumbered from 26-2-7, as last amended by Laws of Utah 2022, Chapter 231)

26B-8-108, (Renumbered from 26-2-8, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-109, (Renumbered from 26-2-9, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-110, (Renumbered from 26-2-10, as last amended by Laws of Utah 2021, Chapter 65)

26B-8-111, (Renumbered from 26-2-11, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-112, (Renumbered from 26-2-12.5, as last amended by Laws of Utah 2022, Chapters 255 and 335)

26B-8-113, (Renumbered from 26-2-12.6, as last amended by Laws of Utah 2022, Chapters 255 and 365)

26B-8-114, (Renumbered from 26-2-13, as last amended by Laws of Utah 2021, Chapters 11 and 297)

26B-8-115, (Renumbered from 26-2-14, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-116, (Renumbered from 26-2-14.1, as enacted by Laws of Utah 2002, Chapter 69)

26B-8-117, (Renumbered from 26-2-14.2, as enacted by Laws of Utah 2002, Chapter 69)

26B-8-118, (Renumbered from 26-2-14.3, as enacted by Laws of Utah 2015, Chapter 184)

26B-8-119, (Renumbered from 26-2-15, as last amended by Laws of Utah 2020, Chapter 201)

26B-8-120, (Renumbered from 26-2-16, as last amended by Laws of Utah 2009, Chapters 66 and 68)

26B-8-121, (Renumbered from 26-2-17, as last amended by Laws of Utah 2020, Chapter 251)

26B-8-122, (Renumbered from 26-2-18, as last amended by Laws of Utah 2020, Chapter 251)

26B-8-123, (Renumbered from 26-2-19, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-124, (Renumbered from 26-2-21, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-125, (Renumbered from 26-2-22, as last amended by Laws of Utah 2021, Chapter 262)

26B-8-126, (Renumbered from 26-2-23, as last amended by Laws of Utah 2009, Chapter 68)

26B-8-127, (Renumbered from 26-2-24, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-128, (Renumbered from 26-2-25, as last amended by Laws of Utah 2021, Chapter 65)

26B-8-129, (Renumbered from 26-2-26, as last amended by Laws of Utah 1995,

Chapter 202)

26B-8-130, (Renumbered from 26-2-27, as last amended by Laws of Utah 2011, Chapter 366)

26B-8-131, (Renumbered from 26-2-28, as last amended by Laws of Utah 2021, Chapter 65)

26B-8-132, (Renumbered from 26-34-4, as enacted by Laws of Utah 2020, Chapter 353)

26B-8-133, (Renumbered from 26-23-5, as last amended by Laws of Utah 1995, Chapter 202)

26B-8-134, (Renumbered from 26-23-5.5, as enacted by Laws of Utah 1995, Chapter 202)

26B-8-201, (Renumbered from 26-4-2, as last amended by Laws of Utah 2022, Chapter 277)

26B-8-202, (Renumbered from 26-4-4, as last amended by Laws of Utah 2015, Chapter 72)

26B-8-203, (Renumbered from 26-4-5, as last amended by Laws of Utah 1993, Chapter 227)

26B-8-204, (Renumbered from 26-4-6, as last amended by Laws of Utah 2009, Chapter 63)

26B-8-205, (Renumbered from 26-4-7, as last amended by Laws of Utah 2021, Chapter 25)

26B-8-206, (Renumbered from 26-4-8, as last amended by Laws of Utah 1993, Chapter 38)

26B-8-207, (Renumbered from 26-4-9, as last amended by Laws of Utah 2021, Chapter 297)

26B-8-208, (Renumbered from 26-2-18.5, as last amended by Laws of Utah 2019, Chapter 189)

26B-8-209, (Renumbered from 26-4-10, as last amended by Laws of Utah 2021, Chapter 25)

26B-8-210, (Renumbered from 26-4-10.5, as last amended by Laws of Utah 2022,

Chapter 415)

26B-8-211, (Renumbered from 26-4-11, as last amended by Laws of Utah 2018, Chapter 414)

26B-8-212, (Renumbered from 26-4-12, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-213, (Renumbered from 26-4-13, as last amended by Laws of Utah 2001, Chapter 278)

26B-8-214, (Renumbered from 26-4-14, as last amended by Laws of Utah 2021, Chapter 297)

26B-8-215, (Renumbered from 26-4-15, as enacted by Laws of Utah 1981, Chapter 126)

26B-8-216, (Renumbered from 26-4-16, as last amended by Laws of Utah 2007, Chapter 144)

26B-8-217, (Renumbered from 26-4-17, as last amended by Laws of Utah 2022, Chapter 255)

26B-8-218, (Renumbered from 26-4-18, as enacted by Laws of Utah 1981, Chapter 126)

26B-8-219, (Renumbered from 26-4-19, as last amended by Laws of Utah 1993, Chapter 38)

26B-8-220, (Renumbered from 26-4-20, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-221, (Renumbered from 26-4-21, as last amended by Laws of Utah 1997, Chapter 372)

26B-8-222, (Renumbered from 26-4-22, as enacted by Laws of Utah 1981, Chapter 126)

26B-8-223, (Renumbered from 26-4-23, as enacted by Laws of Utah 1981, Chapter 126)

26B-8-224, (Renumbered from 26-4-24, as last amended by Laws of Utah 1997, Chapter 375)

26B-8-225, (Renumbered from 26-4-25, as repealed and reenacted by Laws of Utah 2015, Chapter 72)

26B-8-226, (Renumbered from 26-4-26, as enacted by Laws of Utah 1997, Chapter 232)

26B-8-227, (Renumbered from 26-4-27, as enacted by Laws of Utah 1998, Chapter 153)

26B-8-228, (Renumbered from 26-4-28, as last amended by Laws of Utah 2013, Chapter 167)

26B-8-229, (Renumbered from 26-4-28.5, as enacted by Laws of Utah 2017, Chapter 346)

26B-8-230, (Renumbered from 26-4-29, as last amended by Laws of Utah 2010, Chapter 218)

26B-8-231, (Renumbered from 26-4-30, as enacted by Laws of Utah 2020, Chapter 201)

26B-8-301, (Renumbered from 26-28-102, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-302, (Renumbered from 26-28-103, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-303, (Renumbered from 26-28-104, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-304, (Renumbered from 26-28-105, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-305, (Renumbered from 26-28-106, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-306, (Renumbered from 26-28-107, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-307, (Renumbered from 26-28-108, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-308, (Renumbered from 26-28-109, as last amended by Laws of Utah 2018, Chapter 48)

26B-8-309, (Renumbered from 26-28-110, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-310, (Renumbered from 26-28-111, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-311, (Renumbered from 26-28-112, as last amended by Laws of Utah 2014, Chapter 189)

26B-8-312, (Renumbered from 26-28-113, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-313, (Renumbered from 26-28-114, as last amended by Laws of Utah 2019, Chapter 349)

26B-8-314, (Renumbered from 26-28-115, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-315, (Renumbered from 26-28-116, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-316, (Renumbered from 26-28-117, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-317, (Renumbered from 26-28-118, as last amended by Laws of Utah 2018, Chapter 48)

26B-8-318, (Renumbered from 26-28-119, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-319, (Renumbered from 26-28-120, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-320, (Renumbered from 26-28-121, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-321, (Renumbered from 26-28-122, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-322, (Renumbered from 26-28-123, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-323, (Renumbered from 26-28-124, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-324, (Renumbered from 26-28-125, as enacted by Laws of Utah 2007, Chapter 60)

26B-8-401, (Renumbered from 26-3-1, as last amended by Laws of Utah 1995, Chapter

202)

26B-8-402, (Renumbered from 26-3-2, as enacted by Laws of Utah 1981, Chapter 126)

26B-8-403, (Renumbered from 26-3-4, as enacted by Laws of Utah 1981, Chapter 126)

26B-8-404, (Renumbered from 26-3-5, as last amended by Laws of Utah 1996, Chapter 201)

26B-8-405, (Renumbered from 26-3-6, as last amended by Laws of Utah 1996, Chapter 201)

26B-8-406, (Renumbered from 26-3-7, as last amended by Laws of Utah 2013, Chapter 278)

26B-8-407, (Renumbered from 26-3-8, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-408, (Renumbered from 26-3-9, as last amended by Laws of Utah 1996, Chapter 201)

26B-8-409, (Renumbered from 26-3-10, as last amended by Laws of Utah 1996, Chapter 201)

26B-8-410, (Renumbered from 26-3-11, as last amended by Laws of Utah 2005, Chapter 243)

26B-8-411, (Renumbered from 26-1-37, as last amended by Laws of Utah 2019, Chapter 105)

26B-8-501, (Renumbered from 26-33a-102, as last amended by Laws of Utah 2022, Chapter 255)

26B-8-502, (Renumbered from 26-33a-105, as enacted by Laws of Utah 1990, Chapter 305)

26B-8-503, (Renumbered from 26-33a-106, as last amended by Laws of Utah 1996, Chapter 201)

26B-8-504, (Renumbered from 26-33a-106.1, as last amended by Laws of Utah 2022, Chapter 321)

26B-8-505, (Renumbered from 26-33a-106.5, as last amended by Laws of Utah 2019, Chapter 370)

26B-8-506, (Renumbered from 26-33a-107, as last amended by Laws of Utah 2016,

Chapter 74)

26B-8-507, (Renumbered from 26-33a-108, as last amended by Laws of Utah 1996, Chapter 201)

26B-8-508, (Renumbered from 26-33a-109, as last amended by Laws of Utah 2021, Chapter 277)

26B-8-509, (Renumbered from 26-33a-110, as enacted by Laws of Utah 1990, Chapter 305)

26B-8-510, (Renumbered from 26-33a-111, as last amended by Laws of Utah 2011, Chapter 297)

26B-8-511, (Renumbered from 26-33a-115, as enacted by Laws of Utah 2013, Chapter 102)

26B-8-512, (Renumbered from 26-33a-116, as enacted by Laws of Utah 2019, Chapter 287)

26B-8-513, (Renumbered from 26-33a-117, as enacted by Laws of Utah 2020, Chapter 181)

26B-8-514, (Renumbered from 26-70-102, as enacted by Laws of Utah 2022, Chapter 327)

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

Section 1. Section **26B-3-101** is amended to read:

CHAPTER 3. HEALTH CARE - DELIVERY AND ASSISTANCE

Part 1. Health Care Assistance

26B-3-101. Definitions.

[~~Reserved~~]

As used in this chapter:

(1) "Applicant" means any person who requests assistance under the medical programs of the state.

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

(3) "Division" means the Division of Integrated Healthcare within the department, established under Section 26-X-XXX.

(4) "Enrollee" or "member" means an individual whom the department has determined to be eligible for assistance under the Medicaid program.

(5) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.

(6) "Medical assistance" means services furnished or payments made to or on behalf of a member.

(7) (a) "Passenger vehicle" means a self-propelled, two-axle vehicle intended primarily for operation on highways and used by an applicant or recipient to meet basic transportation needs and has a fair market value below 40% of the applicable amount of the federal luxury passenger automobile tax established in 26 U.S.C. Sec. 4001 and adjusted annually for inflation.

(b) "Passenger vehicle" does not include:

(i) a commercial vehicle, as defined in Section 41-1a-102;

(ii) an off-highway vehicle, as defined in Section 41-1a-102; or

(iii) a motor home, as defined in Section 13-14-102.

(8) "PPACA" means the same as that term is defined in Section 31A-1-301.

(9) "Recipient" means a person who has received medical assistance under the Medicaid program.

Section 2. Section **26B-3-102**, which is renumbered from Section 26-18-2.1 is renumbered and amended to read:

[~~26-18-2.1~~]. 26B-3-102. Division -- Creation.

There is created, within the department, the Division of [~~Medicaid and Health Financing~~] Integrated Healthcare which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Children's Health Insurance Program established in Section [~~26-40-103~~] 26B-3-XXX, in accordance with the provisions of this chapter and applicable federal law.

Section 3. Section **26B-3-103**, which is renumbered from Section 26-18-2.2 is renumbered and amended to read:

[~~26-18-2.2~~]. 26B-3-103. State Medicaid director -- Appointment -- Responsibilities.

(1) The state Medicaid director shall be appointed by the governor, after consultation with the executive director, with the advice and consent of the Senate.

(2) The state Medicaid director may employ other employees as necessary to implement the provisions of this chapter, and shall:

[~~(1)~~] (a) administer the responsibilities of the division as set forth in this chapter;

[~~(2)~~] (b) administer the division's budget; and

[~~(3)~~] (c) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

Section 4. Section **26B-3-104**, which is renumbered from Section 26-18-2.3 is renumbered and amended to read:

[~~26-18-2.3~~]. 26B-3-104. Division responsibilities -- Emphasis -- Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:

(a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;

(b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and

(c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

(2) The division shall implement and utilize cost-containment methods, where possible, which may include:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) consistent with Sections [~~26-18-2.4~~] 26B-3-105 and 58-17b-606, a Medicaid drug

program;

(g) coordination of benefits; and

(h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

(3) The state Medicaid director shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

(4) (a) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, and cost avoidance.

(b) The department shall coordinate with the Office of the Inspector General for Medicaid Services created in Section 63A-13-201 to implement Subsection (2) and to address Medicaid fraud, waste, or abuse as described in Section 63A-13-202.

Section 5. Section **26B-3-105**, which is renumbered from Section 26-18-2.4 is renumbered and amended to read:

[~~26-18-2.4~~]. 26B-3-105. Medicaid drug program -- Preferred drug list.

(1) A Medicaid drug program developed by the department under Subsection [~~26-18-2.3~~] 26B-3-104(2)(f):

(a) shall, notwithstanding Subsection [~~26-18-2.3~~] 26B-3-104(1)(b), be based on clinical and cost-related factors which include medical necessity as determined by a provider in accordance with administrative rules established by the Drug Utilization Review Board;

(b) may include therapeutic categories of drugs that may be exempted from the drug program;

(c) may include placing some drugs, except the drugs described in Subsection (2), on a preferred drug list:

(i) to the extent determined appropriate by the department; and

(ii) in the manner described in Subsection (3) for psychotropic drugs;

(d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, and except as provided in Subsection (3), shall immediately implement the prior authorization requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:

(i) on the preferred drug list on the date that this act takes effect; or

(ii) added to the preferred drug list after this act takes effect; and

(e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior authorization requirements established under Subsections (1)(c) and (d) which shall permit a health care provider or the health care provider's agent to obtain a prior authorization override of the preferred drug list through the department's pharmacy prior authorization review process, and which shall:

(i) provide either telephone or fax approval or denial of the request within 24 hours of the receipt of a request that is submitted during normal business hours of Monday through Friday from 8 a.m. to 5 p.m.;

(ii) provide for the dispensing of a limited supply of a requested drug as determined appropriate by the department in an emergency situation, if the request for an override is received outside of the department's normal business hours; and

(iii) require the health care provider to provide the department with documentation of the medical need for the preferred drug list override in accordance with criteria established by the department in consultation with the Pharmacy and Therapeutics Committee.

(2) (a) [~~For purposes of~~] As used in this Subsection (2):

(i) "Immunosuppressive drug":

(A) means a drug that is used in immunosuppressive therapy to inhibit or prevent activity of the immune system to aid the body in preventing the rejection of transplanted organs and tissue; and

(B) does not include drugs used for the treatment of autoimmune disease or diseases that are most likely of autoimmune origin.

(ii) "Stabilized" means a health care provider has documented in the patient's medical chart that a patient has achieved a stable or steadfast medical state within the past 90 days using a particular psychotropic drug.

(b) A preferred drug list developed under the provisions of this section may not include an immunosuppressive drug.

(c) (i) The state Medicaid program shall reimburse for a prescription for an immunosuppressive drug as written by the health care provider for a patient who has undergone an organ transplant.

(ii) For purposes of Subsection 58-17b-606(4), and with respect to patients who have undergone an organ transplant, the prescription for a particular immunosuppressive drug as written by a health care provider meets the criteria of demonstrating to the department a medical necessity for dispensing the prescribed immunosuppressive drug.

(d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the state Medicaid drug program may not require the use of step therapy for immunosuppressive drugs without the written or oral consent of the health care provider and the patient.

(e) The department may include a sedative hypnotic on a preferred drug list in accordance with Subsection (2)(f).

(f) The department shall grant a prior authorization for a sedative hypnotic that is not on the preferred drug list under Subsection (2)(e), if the health care provider has documentation related to one of the following conditions for the Medicaid client:

(i) a trial and failure of at least one preferred agent in the drug class, including the name of the preferred drug that was tried, the length of therapy, and the reason for the discontinuation;

(ii) detailed evidence of a potential drug interaction between current medication and the preferred drug;

(iii) detailed evidence of a condition or contraindication that prevents the use of the preferred drug;

(iv) objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange with a preferred drug;

(v) the patient is a new or previous Medicaid client with an existing diagnosis previously stabilized with a nonpreferred drug; or

(vi) other valid reasons as determined by the department.

(g) A prior authorization granted under Subsection (2)(f) is valid for one year from the date the department grants the prior authorization and shall be renewed in accordance with Subsection (2)(f).

(3) (a) [~~For purposes of~~] As used in this Subsection (3), "psychotropic drug" means the following classes of drugs:

(i) atypical anti-psychotic;

(ii) anti-depressant;

(iii) anti-convulsant/mood stabilizer;

(iv) anti-anxiety; and

(v) attention deficit hyperactivity disorder stimulant.

(b) (i) The department shall develop a preferred drug list for psychotropic drugs.

(ii) Except as provided in Subsection (3)(d), a preferred drug list for psychotropic drugs developed under this section shall allow a health care provider to override the preferred drug list by writing "dispense as written" on the prescription for the psychotropic drug.

(iii) A health care provider may not override Section 58-17b-606 by writing "dispense as written" on a prescription.

(c) The department, and a Medicaid accountable care organization that is responsible for providing behavioral health, shall:

(i) establish a system to:

(A) track health care provider prescribing patterns for psychotropic drugs;

(B) educate health care providers who are not complying with the preferred drug list; and

(C) implement peer to peer education for health care providers whose prescribing practices continue to not comply with the preferred drug list; and

(ii) determine whether health care provider compliance with the preferred drug list is at least:

(A) 55% of prescriptions by July 1, 2017;

(B) 65% of prescriptions by July 1, 2018; and

(C) 75% of prescriptions by July 1, 2019.

(d) Beginning October 1, 2019, the department shall eliminate the dispense as written override for the preferred drug list, and shall implement a prior authorization system for psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has not realized annual savings from implementing the preferred drug list for psychotropic drugs of at least $750,000 General Fund savings.

Section 6. Section **26B-3-106**, which is renumbered from Section 26-18-2.5 is renumbered and amended to read:

[~~26-18-2.5~~]. 26B-3-106. Simplified enrollment and renewal process for Medicaid and other state medical programs -- Financial institutions.

(1) The department may apply for grants and accept donations to make technology system improvements necessary to implement a simplified enrollment and renewal process for the Medicaid program, Utah Premium Partnership, and Primary Care Network Demonstration Project programs.

(2) (a) The department may enter into an agreement with a financial institution doing business in the state to develop and operate a data match system to identify an applicant's or enrollee's assets that:

(i) uses automated data exchanges to the maximum extent feasible; and

(ii) requires a financial institution each month to provide the name, record address, Social Security number, other taxpayer identification number, or other identifying information for each applicant or enrollee who maintains an account at the financial institution.

(b) The department may pay a reasonable fee to a financial institution for compliance with this Subsection (2), as provided in Section 7-1-1006.

(c) A financial institution may not be liable under any federal or state law to any person for any disclosure of information or action taken in good faith under this Subsection (2).

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

Section 7. Section **26B-3-107**, which is renumbered from Section 26-18-2.6 is renumbered and amended to read:

[~~26-18-2.6~~]. 26B-3-107. Dental benefits.

(1) (a) Except as provided in Subsection (8), the division may establish a competitive bid process to bid out Medicaid dental benefits under this chapter.

(b) The division may bid out the Medicaid dental benefits separately from other program benefits.

(2) The division shall use the following criteria to evaluate dental bids:

(a) ability to manage dental expenses;

(b) proven ability to handle dental insurance;

(c) efficiency of claim paying procedures;

(d) provider contracting, discounts, and adequacy of network; and

(e) other criteria established by the department.

(3) The division shall request bids for the program's benefits at least once every five years.

(4) The division's contract with dental plans for the program's benefits shall include risk sharing provisions in which the dental plan must accept 100% of the risk for any difference between the division's premium payments per client and actual dental expenditures.

(5) The division may not award contracts to:

(a) more than three responsive bidders under this section; or

(b) an insurer that does not have a current license in the state.

(6) (a) The division may cancel the request for proposals if:

(i) there are no responsive bidders; or

(ii) the division determines that accepting the bids would increase the program's costs.

(b) If the division cancels a request for proposal or a contract that results from a request for proposal described in Subsection (6)(a), the division shall report to the Health and Human Services Interim Committee regarding the reasons for the decision.

(7) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.

(8) (a) The division may:

(i) establish a dental health care delivery system and payment reform pilot program for Medicaid dental benefits to increase access to cost effective and quality dental health care by increasing the number of dentists available for Medicaid dental services; and

(ii) target specific Medicaid populations or geographic areas in the state.

(b) The pilot program shall establish compensation models for dentists and dental hygienists that:

(i) increase access to quality, cost effective dental care; and

(ii) use funds from the Division of Family Health and Preparedness that are available to reimburse dentists for educational loans in exchange for the dentist agreeing to serve Medicaid and under-served populations.

(c) The division may amend the state plan and apply to the Secretary of the United States Department of Health and Human Services for waivers or pilot programs if necessary to establish the new dental care delivery and payment reform model.

(d) The division shall evaluate the pilot program's effect on the cost of dental care and access to dental care for the targeted Medicaid populations.

(9) (a) As used in this Subsection (9), "dental hygienist" means an individual who is licensed as a dental hygienist under Section 58-69-301.

(b) The department shall reimburse a dental hygienist for dental services performed in a public health setting and in accordance with Subsection (9)(c) beginning on the earlier of:

(i) January 1, 2023; or

(ii) 30 days after the date on which the replacement of the department's Medicaid Management Information System software is complete.

(c) The department shall reimburse a dental hygienist directly for a service provided through the Medicaid program if:

(i) the dental hygienist requests to be reimbursed directly; and

(ii) the dental hygienist provides the service within the scope of practice described in Section 58-69-801.

(d) Before November 30 of each year in which the department reimburses dental hygienists in accordance with Subsection (9)(c), the department shall report to the Health and Human Services Interim Committee, for the previous fiscal year:

(i) the number and geographic distribution of dental hygienists who requested to be reimbursed directly;

(ii) the total number of Medicaid enrollees who were served by a dental hygienist who were reimbursed under this Subsection (9);

(iii) the total amount reimbursed directly to dental hygienists under this Subsection (9);

(iv) the specific services and billing codes that are reimbursed under this Subsection (9); and

(v) the aggregate amount reimbursed for each service and billing code described in Subsection (9)(d)(iv).

(e) (i) Except as provided in this Subsection (9), nothing in this Subsection (9) shall be interpreted as expanding or otherwise altering the limitations and scope of practice for a dental hygienist.

(ii) A dental hygienist may only directly bill and receive compensation for billing codes that fall within the scope of practice of a dental hygienist.

Section 8. Section **26B-3-108**, which is renumbered from Section 26-18-3 is renumbered and amended to read:

[~~26-18-3~~]. 26B-3-108. Administration of Medicaid program by department -- Reporting to the Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility standards -- Internal audits -- Health opportunity accounts.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) (a) The department shall implement the Medicaid program through administrative rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the requirements of Title XIX, and applicable federal regulations.

(b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules necessary to implement the program:

(i) the standards used by the department for determining eligibility for Medicaid services;

(ii) the services and benefits to be covered by the Medicaid program;

(iii) reimbursement methodologies for providers under the Medicaid program; and

(iv) a requirement that:

(A) a person receiving Medicaid services shall participate in the electronic exchange of clinical health records established in accordance with Section [~~26-1-37~~] 26B-X-XXX unless the individual opts out of participation;

(B) prior to enrollment in the electronic exchange of clinical health records the enrollee shall receive notice of enrollment in the electronic exchange of clinical health records and the right to opt out of participation at any time; and

(C) beginning July 1, 2012, when the program sends enrollment or renewal information to the enrollee and when the enrollee logs onto the program's website, the enrollee shall receive notice of the right to opt out of the electronic exchange of clinical health records.

(3) (a) The department shall, in accordance with Subsection (3)(b), report to the Social Services Appropriations Subcommittee when the department:

(i) implements a change in the Medicaid State Plan;

(ii) initiates a new Medicaid waiver;

(iii) initiates an amendment to an existing Medicaid waiver;

(iv) applies for an extension of an application for a waiver or an existing Medicaid

waiver;

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

(vi) initiates a rate change that requires public notice under state or federal law.

(b) The report required by Subsection (3)(a) shall:

(i) be submitted to the Social Services Appropriations Subcommittee prior to the department implementing the proposed change; and

(ii) include:

(A) a description of the department's current practice or policy that the department is proposing to change;

(B) an explanation of why the department is proposing the change;

(C) the proposed change in services or reimbursement, including a description of the effect of the change;

(D) the effect of an increase or decrease in services or benefits on individuals and families;

(E) the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and

(F) the fiscal impact of the proposed change, including:

(I) the effect of the proposed change on current or future appropriations from the Legislature to the department;

(II) the effect the proposed change may have on federal matching dollars received by the state Medicaid program;

(III) any cost shifting or cost savings within the department's budget that may result from the proposed change; and

(IV) identification of the funds that will be used for the proposed change, including any transfer of funds within the department's budget.

(4) Any rules adopted by the department under Subsection (2) are subject to review and reauthorization by the Legislature in accordance with Section 63G-3-502.

(5) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including:

(a) the determination of the eligibility of individuals for the program;

(b) recovery of overpayments; and

(c) consistent with Section [~~26-20-13~~] 26B-X-XXX, and to the extent permitted by law and quality control services, enforcement of fraud and abuse laws.

(6) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(7) (a) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as dedicated credits to be used by the division in accordance with the requirements of Section 1919 of Title XIX of the federal Social Security Act.

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

(8) (a) In determining whether an applicant or recipient is eligible for a service or benefit under this part or [~~Chapter 40, Utah Children's Health Insurance Act~~] Part X, Children's Health Insurance Program, the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.

(b) Before Subsection (8)(a) may be applied:

(i) the federal government shall:

(A) determine that Subsection (8)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;

(B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or

(C) determine that the state's waivers that permit dual eligibility determinations for cash assistance and Medicaid are no longer valid; and

(ii) the department shall determine that Subsection (8)(a) can be implemented within existing funding.

(9) (a) [~~For purposes of~~] As used in this Subsection (9):

(i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as

defined in 42 U.S.C. Sec. 1382c(a)(1); and

(ii) "spend down" means an amount of income in excess of the allowable income standard that shall be paid in cash to the department or incurred through the medical services not paid by Medicaid.

(b) In determining whether an applicant or recipient who is aged, blind, or has a disability is eligible for a service or benefit under this chapter, the department shall use 100% of the federal poverty level as:

(i) the allowable income standard for eligibility for services or benefits; and

(ii) the allowable income standard for eligibility as a result of spend down.

(10) The department shall conduct internal audits of the Medicaid program.

(11) (a) The department may apply for and, if approved, implement a demonstration program for health opportunity accounts, as provided for in 42 U.S.C. Sec. 1396u-8.

(b) A health opportunity account established under Subsection (11)(a) shall be an alternative to the existing benefits received by an individual eligible to receive Medicaid under this chapter.

(c) Subsection (11)(a) is not intended to expand the coverage of the Medicaid program.

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

(A) medically needy pregnant women;

(B) medically needy children; and

(C) medically needy parents and caretaker relatives.

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

(b) In determining whether an applicant is eligible for benefits described in Subsection (12)(a)(i), the department shall:

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

(A) under the age of 26; and

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

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

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

(i) incarcerated; and

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

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

(14) The department is a party to, and may intervene at any time in, any judicial or administrative action:

(a) to which the Department of Workforce Services is a party; and

(b) that involves medical assistance under[~~:~~] this chapter.

[~~(i) Title 26, Chapter 18, Medical Assistance Act; or~~]

[~~(ii) Title 26, Chapter 40, Utah Children's Health Insurance Act.~~]

Section 9. Section **26B-3-109**, which is renumbered from Section 26-18-3.1 is renumbered and amended to read:

[~~26-18-3.1~~]. 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 [~~26-18-3.9~~] 26B-3-113(2).

(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 10. Section **26B-3-110**, which is renumbered from Section 26-18-3.5 is renumbered and amended to read:

[~~26-18-3.5~~]. 26B-3-110. Copayments by recipients -- Employer sponsored plans.

(1) The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

(2) Beginning May 1, 2006, within appropriations by the Legislature and as a means to increase health care coverage among the uninsured, the department shall take steps to promote increased participation in employer sponsored health insurance, including:

(a) maximizing the health insurance premium subsidy provided under the state's 1115 demonstration waiver by:

(i) ensuring that state funds are matched by federal funds to the greatest extent allowable; and

(ii) as the department determines appropriate, seeking federal approval to do one or more of the following:

(A) eliminate or otherwise modify the annual enrollment fee;

(B) eliminate or otherwise modify the schedule used to determine the level of subsidy provided to an enrollee each year;

(C) reduce the maximum number of participants allowable under the subsidy program; or

(D) otherwise modify the program in a manner that promotes enrollment in employer sponsored health insurance; and

(b) exploring the use of other options, including the development of a waiver under the Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

Section 11. Section **26B-3-111**, which is renumbered from Section 26-18-3.6 is renumbered and amended to read:

[~~26-18-3.6~~]. 26B-3-111. Income and resources from institutionalized spouses.

(1) As used in this section:

(a) "Community spouse" means the spouse of an institutionalized spouse.

(b) (i) "Community spouse monthly income allowance" means an amount by which the minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly income otherwise available to the community spouse, determined without regard to the allowance, except as provided in Subsection (1)(b)(ii).

(ii) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse may not be less than the amount of the monthly income so ordered.

(c) "Community spouse resource allowance" is the amount of combined resources that are protected for a community spouse living in the community, which the division shall establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the United States Department of Health and Human Services.

(d) "Excess shelter allowance" for a community spouse means the amount by which the sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case of condominium or cooperative, required maintenance charge, for the community spouse's principal residence and the spouse's actual expenses for electricity, natural gas, and water utilities or, at the discretion of the department, the federal standard utility allowance under SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection (9).

(e) "Family member" means a minor dependent child, dependent parents, or dependent sibling of the institutionalized spouse or community spouse who are residing with the community spouse.

(f) (i) "Institutionalized spouse" means a person who is residing in a nursing facility and is married to a spouse who is not in a nursing facility.

(ii) An "institutionalized spouse" does not include a person who is not likely to reside in a nursing facility for at least 30 consecutive days.

(g) "Nursing care facility" means the same as that term is defined in Section [~~26-21-2~~] 26B-2-201.

(2) The division shall comply with this section when determining eligibility for medical assistance for an institutionalized spouse.

(3) For services furnished during a calendar year beginning on or after January 1, 1999, the community spouse resource allowance shall be increased by the division by an amount as determined annually by CMS.

(4) The division shall compute, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse:

(a) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

(b) a spousal share, which is 1/2 of the resources described in Subsection (4)(a).

(5) At the request of an institutionalized spouse or a community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the division shall promptly assess and document the total value described in Subsection (4)(a) and shall provide a copy of that assessment and documentation to each spouse and shall retain a copy of the assessment. When the division provides a copy of the assessment, it shall include a notice stating that the spouse may request a hearing under Subsection (11).

(6) When determining eligibility for medical assistance under this chapter:

(a) Except as provided in Subsection (6)(b), all resources held by either the institutionalized spouse, community spouse, or both, are considered to be available to the institutionalized spouse.

(b) Resources are considered to be available to the institutionalized spouse only to the extent that the amount of those resources exceeds the community spouse resource allowance at the time of application for medical assistance under this chapter.

(7) (a) The division may not find an institutionalized spouse to be ineligible for medical assistance by reason of resources determined under Subsection (5) to be available for the cost of care when:

(i) the institutionalized spouse has assigned to the state any rights to support from the community spouse;

(ii) except as provided in Subsection (7)(b), the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment; or

(iii) the division determines that denial of medical assistance would cause an undue burden.

(b) Subsection (7)(a)(ii) does not prevent the division from seeking a court order for an assignment of support.

(8) During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is eligible for medical assistance, the resources of the community spouse may not be considered to be available to the institutionalized spouse.

(9) When an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly for the cost of care in the nursing care facility, the division shall deduct from the spouse's monthly income the following amounts in the following order:

(a) a personal needs allowance, the amount of which is determined by the division;

(b) a community spouse monthly income allowance, but only to the extent that the income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;

(c) a family allowance for each family member, equal to at least 1/3 of the amount that the amount described in Subsection (10)(a) exceeds the amount of the family member's monthly income; and

(d) amounts for incurred expenses for the medical or remedial care for the institutionalized spouse.

(10) The division shall establish a minimum monthly maintenance needs allowance for each community spouse that includes:

(a) an amount established by the division by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the United States Department of Health and Human Services; and

(b) an excess shelter allowance.

(11) (a) An institutionalized spouse or a community spouse may request a hearing with respect to the determinations described in Subsections (11)(e)(i) through (v) if an application

for medical assistance has been made on behalf of the institutionalized spouse.

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

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

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

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

(i) the community spouse monthly income allowance;

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

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

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

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

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

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

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

Section 12. Section **26B-3-112**, which is renumbered from Section 26-18-3.8 is

renumbered and amended to read:

[~~26-18-3.8~~]. 26B-3-112. Maximizing use of premium assistance programs -- Utah's Premium Partnership for Health Insurance.

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

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

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

(ii) give priority to, but not be limited to, expanding the state's Utah Premium Partnership for Health Insurance Program, including as required under Subsection (2); and

(iii) encourage the enrollment of all individuals within a household in the same plan, where possible, including enrollment in a plan that allows individuals within the household transitioning out of Medicaid to retain the same network and benefits they had while enrolled in Medicaid.

(2) The department shall seek federal approval of an amendment to the state's Utah Premium Partnership for Health Insurance program to adjust the eligibility determination for single adults and parents who have an offer of employer sponsored insurance. The amendment shall:

(a) be within existing appropriations for the Utah Premium Partnership for Health Insurance program; and

(b) provide that adults who are up to 200% of the federal poverty level are eligible for premium subsidies in the Utah Premium Partnership for Health Insurance program.

(3) For the fiscal year 2020-21, the department shall seek authority to increase the maximum premium subsidy per month for adults under the Utah Premium Partnership for Health Insurance program to $300.

(4) Beginning with the fiscal year 2021-22, and in each subsequent fiscal year, the department may increase premium subsidies for single adults and parents who have an offer of employer-sponsored insurance to keep pace with the increase in insurance premium costs, subject to appropriation of additional funding.

Section 13. Section **26B-3-113**, which is renumbered from Section 26-18-3.9 is renumbered and amended to read:

[~~26-18-3.9~~]. 26B-3-113. Expanding the Medicaid program.

(1) As used in this section:

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

[~~(b)~~] (a) "Federal poverty level" means the same as that term is defined in Section [~~26-18-411~~] 26B-3-XXX.

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

[~~(d)~~] (c) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section [~~26-36b-208~~] 26B-3-XXX.

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

(b) The department shall continue to seek approval from CMS to implement the Medicaid waiver expansion as defined in Section [~~26-18-415~~] 26B-3-XXX.

(c) The department may implement any provision described in Subsections [~~26-18-415~~] 26B-3-XXX(2)(b)(iii) through (viii) in a Medicaid expansion if the department receives approval from CMS to implement that provision.

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

(a) receives approval from CMS to:

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

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

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

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

(i) the Medicaid Expansion Fund;

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

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

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

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

(i) receives approval from CMS to:

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

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

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

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

(A) the Medicaid Expansion Fund;

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

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

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

(b) The department shall submit a waiver, an amendment to an existing waiver, or a

state plan amendment to CMS to:

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

(ii) limit, in certain circumstances as defined by the department, the ability of a qualified entity to determine presumptive eligibility for Medicaid coverage for an individual enrolled in a Medicaid expansion under this Subsection (4);

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

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

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

(5) (a) (i) If CMS does not approve a waiver to expand the Medicaid program in accordance with Subsection (4)(a) on or before January 1, 2020, the department shall develop proposals to implement additional flexibilities and cost controls, including cost sharing tools, within a Medicaid expansion under this Subsection (5) through a request to CMS for a waiver or state plan amendment.

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

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

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

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

(b) Notwithstanding Sections [~~26-18-18~~] 26B-3-XXX and 63J-5-204, and in accordance with this Subsection (5), eligibility for the Medicaid program shall be expanded to include all persons in the optional Medicaid expansion population under [~~the Patient Protection~~

~~and Affordable Care Act, Pub. L. No. 111-148~~] 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 [~~26-18-415~~] 26B-3-XXX(2)(b)(iii) through (viii) in a Medicaid expansion under this Subsection (5);

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

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

(d) The eligibility criteria in this Subsection (5) shall be construed to include all individuals eligible for the health coverage improvement program under Section [~~26-18-411~~] 26B-3-XXX.

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

(i) the Medicaid Expansion Fund;

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

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

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

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

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

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

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

(i) the governor shall direct the [~~Department of Health, Department of Human Services,~~] 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 of Health, Department of Human Services,~~] 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) into the Medicaid Expansion Fund.

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

(7) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to provide matching funds to the state for the cost of providing Medicaid services to newly enrolled individuals who qualify for Medicaid coverage under a Medicaid expansion.

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

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

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

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

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

(e) as calculated in accordance with Subsections [~~26-36b-204~~] 26B-3-XXX(4) and [~~26-36c-204~~] 26B-3-XXX(2), the state's net cost of the qualified Medicaid expansion.

Section 14. Section **26B-3-114**, which is renumbered from Section 26-18-4 is renumbered and amended to read:

[~~26-18-4~~]. 26B-3-114. Department standards for eligibility under Medicaid -- Funds for abortions.

(1) (a) The department may develop standards and administer policies relating to eligibility under the Medicaid program as long as they are consistent with Subsection [~~26-18-3~~] 26B-3-108(8).

(b) An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.

(2) The department may not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.

(4) Any person or organization that, under the guise of other medical treatment, provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

Section 15. Section **26B-3-115**, which is renumbered from Section 26-18-5 is renumbered and amended to read:

[~~26-18-5~~]. 26B-3-115. Contracts for provision of medical services -- Federal provisions modifying department rules -- Compliance with Social Security Act.

(1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other government entities, contracts shall provide that other government entities, in compliance with state and federal law regarding intergovernmental transfers,

transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.

(2) Contract terms shall include provisions for maintenance, administration, and service costs.

(3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation.

(4) The provisions of this section do not apply to department rules governing abortion.

(5) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

Section 16. Section **26B-3-116**, which is renumbered from Section 26-18-5.5 is renumbered and amended to read:

[~~26-18-5.5~~]. 26B-3-116. Liability insurance required.

The Medicaid program may not reimburse a home health agency, as defined in Section [~~26-21-2~~] 26B-2-201, for home health services provided to an enrollee unless the home health agency has liability coverage of:

(1) at least $500,000 per incident; or

(2) an amount established by department rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 17. Section **26B-3-117**, which is renumbered from Section 26-18-6 is renumbered and amended to read:

[~~26-18-6~~]. 26B-3-117. Federal aid -- Authority of executive director.

(1) The executive director, with the approval of the governor, may bind the state to any executive or legislative provisions promulgated or enacted by the federal government which invite the state to participate in the distribution, disbursement or administration of any fund or service advanced, offered or contributed in whole or in part by the federal government for purposes consistent with the powers and duties of the department.

(2) Such funds shall be used as provided in this chapter and be administered by the department for purposes related to medical assistance programs.

Section 18. Section **26B-3-118**, which is renumbered from Section 26-18-7 is renumbered and amended to read:

[~~26-18-7~~]. 26B-3-118. Medical vendor rates.

(1) Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division.

(2) As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

Section 19. Section **26B-3-119**, which is renumbered from Section 26-18-8 is renumbered and amended to read:

[~~26-18-8~~]. 26B-3-119. Enforcement of public assistance statutes.

(1) The department shall enforce or contract for the enforcement of Sections 35A-1-503, 35A-3-108, 35A-3-110, 35A-3-111, 35A-3-112, and 35A-3-603 to the extent that these sections pertain to benefits conferred or administered by the division under this chapter, to the extent allowed under federal law or regulation.

(2) The department may contract for services covered in Section 35A-3-111 insofar as that section pertains to benefits conferred or administered by the division under this chapter.

Section 20. Section **26B-3-120**, which is renumbered from Section 26-18-9 is renumbered and amended to read:

[~~26-18-9~~]. 26B-3-120. Prohibited acts of state or local employees of Medicaid program -- Violation a misdemeanor.

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

(2) Violation of this section is a class A misdemeanor.

Section 21. Section **26B-3-121**, which is renumbered from Section 26-18-11 is

renumbered and amended to read:

[~~26-18-11~~]. 26B-3-121. Rural hospitals.

(1) [~~For purposes of~~] As used in this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.

(2) For purposes of the Medicaid program, the [~~Division of Medicaid and Health Financing~~] division may not discriminate among rural hospitals on the basis of size.

Section 22. Section **26B-3-122**, which is renumbered from Section 26-18-13 is renumbered and amended to read:

[~~26-18-13~~]. 26B-3-122. Telemedicine -- Reimbursement -- Rulemaking.

(1) (a) As used in this section, communication by telemedicine is considered face-to-face contact between a health care provider and a patient under the state's medical assistance program if:

(i) the communication by telemedicine meets the requirements of administrative rules adopted in accordance with Subsection (3); and

(ii) the health care services are eligible for reimbursement under the state's medical assistance program.

(b) This Subsection (1) applies to any managed care organization that contracts with the state's medical assistance program.

(2) The reimbursement rate for telemedicine services approved under this section:

(a) shall be subject to reimbursement policies set by the state plan; and

(b) may be based on:

(i) a monthly reimbursement rate;

(ii) a daily reimbursement rate; or

(iii) an encounter rate.

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

(a) the particular telemedicine services that are considered face-to-face encounters for reimbursement purposes under the state's medical assistance program; and

(b) the reimbursement methodology for the telemedicine services designated under Subsection (3)(a).

Section 23. Section **26B-3-123**, which is renumbered from Section 26-18-13.5 is renumbered and amended to read:

[~~26-18-13.5~~]. 26B-3-123. Reimbursement of telemedicine services and telepsychiatric consultations.

(1) As used in this section:

(a) "Telehealth services" means the same as that term is defined in Section 26-60-102.

(b) "Telemedicine services" means the same as that term is defined in Section 26-60-102.

(c) "Telepsychiatric consultation" means a consultation between a physician and a board certified psychiatrist, both of whom are licensed to engage in the practice of medicine in the state, that utilizes:

(i) the health records of the patient, provided from the patient or the referring physician;

(ii) a written, evidence-based patient questionnaire; and

(iii) telehealth services that meet industry security and privacy standards, including compliance with the:

(A) Health Insurance Portability and Accountability Act; and

(B) Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.

(2) This section applies to:

(a) a managed care organization that contracts with the Medicaid program; and

(b) a provider who is reimbursed for health care services under the Medicaid program.

(3) The Medicaid program shall reimburse for telemedicine services at the same rate that the Medicaid program reimburses for other health care services.

(4) The Medicaid program shall reimburse for telepsychiatric consultations at a rate set by the Medicaid program.

Section 24. Section **26B-3-124**, which is renumbered from Section 26-18-15 is renumbered and amended to read:

[~~26-18-15~~]. 26B-3-124. Process to promote health insurance coverage for children.

(1) The department, in collaboration with the Department of Workforce Services and

the State Board of Education, shall develop a process to promote health insurance coverage for a child in school when:

(a) the child applies for free or reduced price school lunch;

(b) a child enrolls in or registers in school; and

(c) other appropriate school related opportunities.

(2) The department, in collaboration with the Department of Workforce Services, shall promote and facilitate the enrollment of children identified under Subsection (1) without health insurance in the Utah Children's Health Insurance Program, the Medicaid program, or the Utah Premium Partnership for Health Insurance Program.

Section 25. Section **26B-3-125**, which is renumbered from Section 26-18-16 is renumbered and amended to read:

[~~26-18-16~~]. 26B-3-125. Medicaid -- Continuous eligibility -- Promoting payment and delivery reform.

(1) In accordance with Subsection (2), and within appropriations from the Legislature, the department may amend the state Medicaid plan to:

(a) create continuous eligibility for up to 12 months for an individual who has qualified for the state Medicaid program;

(b) provide incentives in managed care contracts for an individual to obtain appropriate care in appropriate settings; and

(c) require the managed care system to accept the risk of managing the Medicaid population assigned to the plan amendment in return for receiving the benefits of providing quality and cost effective care.

(2) If the department amends the state Medicaid plan under Subsection (1)(a) or (b), the department:

(a) shall ensure that the plan amendment:

(i) is cost effective for the state Medicaid program;

(ii) increases the quality and continuity of care for recipients; and

(iii) calculates and transfers administrative savings from continuous enrollment from the Department of Workforce Services to the [~~Department of Health~~] department; and

(b) may limit the plan amendment under Subsection (1)(a) or (b) to select geographic areas or specific Medicaid populations.

(3) The department may seek approval for a state plan amendment, waiver, or a demonstration project from the Secretary of the United States Department of Health and Human Services if necessary to implement a plan amendment under Subsection (1)(a) or (b).

Section 26. Section **26B-3-126**, which is renumbered from Section 26-18-17 is renumbered and amended to read:

[~~26-18-17~~]. 26B-3-126. Patient notice of health care provider privacy practices.

(1) (a) For purposes of this section:

(i) "Health care provider" means a health care provider as defined in Section 78B-3-403 who:

(A) receives payment for medical services from the Medicaid program established in this chapter, or the Children's Health Insurance Program established in [~~Chapter 40, Utah Children's Health Insurance Act~~] Part X, Children's Health Insurance Program; and

(B) submits a patient's personally identifiable information to the Medicaid eligibility database or the Children's Health Insurance Program eligibility database.

(ii) "HIPAA" means 45 C.F.R. Parts 160, 162, and 164, Health Insurance Portability and Accountability Act of 1996, as amended.

(b) Beginning July 1, 2013, this section applies to the Medicaid program, the Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act, and a health care provider.

(2) A health care provider shall, as part of the notice of privacy practices required by HIPAA, provide notice to the patient or the patient's personal representative that the health care provider either has, or may submit, personally identifiable information about the patient to the Medicaid eligibility database and the Children's Health Insurance Program eligibility database.

(3) The Medicaid program and the Children's Health Insurance Program may not give a health care provider access to the Medicaid eligibility database or the Children's Health Insurance Program eligibility database unless the health care provider's notice of privacy practices complies with Subsection (2).

(4) The department may adopt an administrative rule to establish uniform language for the state requirement regarding notice of privacy practices to patients required under Subsection (2).

Section 27. Section **26B-3-127**, which is renumbered from Section 26-18-18 is

renumbered and amended to read:

[~~26-18-18~~]. 26B-3-127. Optional Medicaid expansion.

(1) The department and the governor may not expand the state's Medicaid program under PPACA unless:

(a) the department expands Medicaid in accordance with Section [~~26-18-415~~] 26B-3-XXX; or

(b) (i) the governor or the governor's designee has reported the intention to expand the state Medicaid program under PPACA to the Legislature in compliance with the legislative review process in Section [~~26-18-3~~] 26B-3-108; and

(ii) the governor submits the request for expansion of the Medicaid program for optional populations to the Legislature under the high impact federal funds request process required by Section 63J-5-204.

(2) (a) The department shall request approval from CMS for waivers from federal statutory and regulatory law necessary to implement the health coverage improvement program under Section [~~26-18-411~~] 26B-3-XXX.

(b) The health coverage improvement program under Section [~~26-18-411~~] 26B-3-XXX is not subject to the requirements in Subsection (1).

Section 28. Section **26B-3-128**, which is renumbered from Section 26-18-19 is renumbered and amended to read:

[~~26-18-19~~]. 26B-3-128. Medicaid vision services -- Request for proposals.

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

Section 29. Section **26B-3-129**, which is renumbered from Section 26-18-20 is renumbered and amended to read:

[~~26-18-20~~]. 26B-3-129. Review of claims -- Audit and investigation procedures.

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

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

(b) If the providers and health care professionals do not agree with the rules proposed or adopted by the department under Subsection (1)(a), the providers or health care professionals may:

(i) request a hearing for the proposed administrative rule or seek any other remedies under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) request a review of the rule by the Legislature's Administrative Rules Review and General Oversight Committee created in Section 63G-3-501.

(2) The department shall:

(a) notify and educate providers and health care professionals subject to audit and investigation under the Medicaid program of the providers' and health care professionals' responsibilities and rights under the administrative rules adopted by the department under the provisions of this section;

(b) ensure that the department, or any entity that contracts with the department to conduct audits:

(i) has on staff or contracts with a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited; and

(ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if the provider who is the subject of the audit disputes the findings of the audit;

(c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, as defined in Section 63A-13-102, unless:

(i) there is a determination that the level of payment error involving the provider exceeds a 10% error rate:

(A) for a sample of claims for a particular service code; and

(B) over a three year period of time;

(ii) documented education intervention has failed to correct the level of payment error; and

(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in reimbursement for a particular service code on an annual basis; and

(d) require that any entity with which the office contracts, for the purpose of

conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.

(3) (a) If the department, or a contractor on behalf of the department:

(i) intends to implement the use of extrapolation as a method of auditing claims, the department shall, prior to adopting the extrapolation method of auditing, report its intent to use extrapolation to the Social Services Appropriations Subcommittee; and

(ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the department or the contractor may use extrapolation only for the service code associated with the findings under Subsections (2)(c)(i) through (iii).

(b) (i) If extrapolation is used under this section, a provider may, at the provider's option, appeal the results of the audit based on:

(A) each individual claim; or

(B) the extrapolation sample.

(ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G, General Government, Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid program and its manual or rules, or other laws or rules that may provide remedies to providers.

Section 30. Section **26B-3-130**, which is renumbered from Section 26-18-21 is renumbered and amended to read:

[~~26-18-21~~]. 26B-3-130. Medicaid intergovernmental transfer report -- Approval requirements.

(1) As used in this section:

(a) (i) "Intergovernmental transfer" means the transfer of public funds from:

(A) a local government entity to another nonfederal governmental entity; or

(B) from a nonfederal, government owned health care facility regulated under [~~Chapter 21, Health Care Facility Licensing and Inspection Act~~] Chapter 2, Part 2, Health Care Facility Licensing and Inspection, to another nonfederal governmental entity.

(ii) "Intergovernmental transfer" does not include:

(A) the transfer of public funds from one state agency to another state agency; or

(B) a transfer of funds from the University of Utah Hospitals and Clinics.

(b) (i) "Intergovernmental transfer program" means a federally approved reimbursement program or category that is authorized by the Medicaid state plan or waiver

authority for intergovernmental transfers.

(ii) "Intergovernmental transfer program" does not include the addition of a provider to an existing intergovernmental transfer program.

(c) "Local government entity" means a county, city, town, special service district, local district, or local education agency as that term is defined in Section 63J-5-102.

(d) "Non-state government entity" means a hospital authority, hospital district, health care district, special service district, county, or city.

(2) (a) An entity that receives federal Medicaid dollars from the department as a result of an intergovernmental transfer shall, on or before August 1, 2017, and on or before August 1 each year thereafter, provide the department with:

(i) information regarding the payments funded with the intergovernmental transfer as authorized by and consistent with state and federal law;

(ii) information regarding the entity's ability to repay federal funds, to the extent required by the department in the contract for the intergovernmental transfer; and

(iii) other information reasonably related to the intergovernmental transfer that may be required by the department in the contract for the intergovernmental transfer.

(b) On or before October 15, 2017, and on or before October 15 each subsequent year, the department shall prepare a report for the Executive Appropriations Committee that includes:

(i) the amount of each intergovernmental transfer under Subsection (2)(a);

(ii) a summary of changes to CMS regulations and practices that are known by the department regarding federal funds related to an intergovernmental transfer program; and

(iii) other information the department gathers about the intergovernmental transfer under Subsection (2)(a).

(3) The department shall not create a new intergovernmental transfer program after July 1, 2017, unless the department reports to the Executive Appropriations Committee, in accordance with Section 63J-5-206, before submitting the new intergovernmental transfer program for federal approval. The report shall include information required by Subsection 63J-5-102(1)(d) and the analysis required in Subsections (2)(a) and (b).

(4) (a) The department shall enter into new Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contracts and contract amendments adding

new nursing care facilities and new non-state government entity operators in accordance with this Subsection (4).

(b) (i) If the nursing care facility expects to receive less than $1,000,000 in federal funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program, excluding seed funding and administrative fees paid by the non-state government entity, the department shall enter into a Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract with the non-state government entity operator of the nursing care facility.

(ii) If the nursing care facility expects to receive between $1,000,000 and $10,000,000 in federal funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program, excluding seed funding and administrative fees paid by the non-state government entity, the department shall enter into a Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract with the non-state government entity operator of the nursing care facility after receiving the approval of the Executive Appropriations Committee.

(iii) If the nursing care facility expects to receive more than $10,000,000 in federal funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program, excluding seed funding and administrative fees paid by the non-state government entity, the department may not approve the application without obtaining approval from the Legislature and the governor.

(c) A non-state government entity may not participate in the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program unless the non-state government entity is a special service district, county, or city that operates a hospital or holds a license under Chapter 21, Health Care Facility Licensing and Inspection Act.

(d) Each non-state government entity that participates in the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program shall certify to the department that:

(i) the non-state government entity is a local government entity that is able to make an intergovernmental transfer under applicable state and federal law;

(ii) the non-state government entity has sufficient public funds or other permissible sources of seed funding that comply with the requirements in 42 C.F.R. Part 433, Subpart B;

(iii) the funds received from the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program are:

(A) for each nursing care facility, available for patient care until the end of the non-state government entity's fiscal year; and

(B) used exclusively for operating expenses for nursing care facility operations, patient care, capital expenses, rent, royalties, and other operating expenses; and

(iv) the non-state government entity has completed all licensing, enrollment, and other forms and documents required by federal and state law to register a change of ownership with the department and with CMS.

(5) The department shall add a nursing care facility to an existing Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract if:

(a) the nursing care facility is managed by or affiliated with the same non-state government entity that also manages one or more nursing care facilities that are included in an existing Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract; and

(b) the non-state government entity makes the certification described in Subsection (4)(d)(ii).

(6) The department may not increase the percentage of the administrative fee paid by a non-state government entity to the department under the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program.

(7) The department may not condition participation in the Nursing Care Facility Non-State Government-Owned Upper Payment Limit program on:

(a) a requirement that the department be allowed to direct or determine the types of patients that a non-state government entity will treat or the course of treatment for a patient in a non-state government nursing care facility; or

(b) a requirement that a non-state government entity or nursing care facility post a bond, purchase insurance, or create a reserve account of any kind.

(8) The non-state government entity shall have the primary responsibility for ensuring compliance with Subsection (4)(d)(ii).

(9) (a) The department may not enter into a new Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract before January 1, 2019.

(b) Subsection (9)(a) does not apply to:

(i) a new Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract that was included in the federal funds request summary under Section 63J-5-201 for fiscal year 2018; or

(ii) a nursing care facility that is operated or managed by the same company as a nursing care facility that was included in the federal funds request summary under Section 63J-5-201 for fiscal year 2018.

Section 31. Section **26B-3-131**, which is renumbered from Section 26-18-22 is renumbered and amended to read:

[~~26-18-22~~]. 26B-3-131. Screening, Brief Intervention, and Referral to Treatment Medicaid reimbursement.

(1) As used in this section:

(a) "Controlled substance prescriber" means a controlled substance prescriber, as that term is defined in Section 58-37-6.5, who:

(i) has a record of having completed SBIRT training, in accordance with Subsection 58-37-6.5(2), before providing the SBIRT services; and

(ii) is a Medicaid enrolled health care provider.

(b) "SBIRT" means the same as that term is defined in Section 58-37-6.5.

(2) The department shall reimburse a controlled substance prescriber who provides SBIRT services to a Medicaid enrollee who is 13 years of age or older for the SBIRT services.

Section 32. Section **26B-3-132**, which is renumbered from Section 26-18-23 is renumbered and amended to read:

[~~26-18-23~~]. 26B-3-132. Prescribing policies for opioid prescriptions.

(1) The department may implement a prescribing policy for certain opioid prescriptions that is substantially similar to the prescribing policies required in Section 31A-22-615.5.

(2) The department may amend the state program and apply for waivers for the state program, if necessary, to implement Subsection (1).

Section 33. Section **26B-3-133**, which is renumbered from Section 26-18-24 is renumbered and amended to read:

[~~26-18-24~~]. 26B-3-133. Reimbursement for long-acting reversible contraception immediately following childbirth.

(1) As used in this section, "long-acting reversible contraception" means a contraception method that requires administration less than once per month, including:

(a) an intrauterine device; and

(b) a contraceptive implant.

(2) The division shall separately identify and reimburse, from other labor and delivery services within the Medicaid program, the provision and insertion of long-acting reversible contraception immediately after childbirth.

Section 34. Section **26B-3-134**, which is renumbered from Section 26-18-25 is renumbered and amended to read:

[~~26-18-25~~]. 26B-3-134. Coverage of exome sequence testing.

(1) As used in this section, "exome sequence testing" means a genomic technique for sequencing the genome of an individual for diagnostic purposes.

(2) The Medicaid program shall reimburse for exome sequence testing:

(a) for an enrollee who:

(i) is younger than 21 years of age; and

(ii) who remains undiagnosed after exhausting all other appropriate diagnostic-related tests;

(b) performed by a nationally recognized provider with significant experience in exome sequence testing;

(c) that is medically necessary; and

(d) at a rate set by the Medicaid program.

Section 35. Section **26B-3-135**, which is renumbered from Section 26-18-26 is renumbered and amended to read:

[~~26-18-26~~]. 26B-3-135. Reimbursement for nonemergency secured behavioral health transport providers.

The department may not reimburse a nonemergency secured behavioral health transport provider that is designated under Section [~~26-8a-303~~] 26B-2-XXX.

Section 36. Section **26B-3-136**, which is renumbered from Section 26-18-27 is renumbered and amended to read:

[~~26-18-27~~]. 26B-3-136. Children's Health Care Coverage Program.

(1) As used in this section:

(a) "CHIP" means the Children's Health Insurance Program created in Section [~~26-40-103~~] 26B-2-XXX.

(b) "Program" means the Children's Health Care Coverage Program created in Subsection (2).

(2) (a) There is created the Children's Health Care Coverage Program within the department.

(b) The purpose of the program is to:

(i) promote health insurance coverage for children in accordance with Section 26-18-15;

(ii) conduct research regarding families who are eligible for Medicaid and CHIP to determine awareness and understanding of available coverage;

(iii) analyze trends in disenrollment and identify reasons that families may not be renewing enrollment, including any barriers in the process of renewing enrollment;

(iv) administer surveys to recently enrolled CHIP and children's Medicaid enrollees to identify:

(A) how the enrollees learned about coverage; and

(B) any barriers during the application process;

(v) develop promotional material regarding CHIP and children's Medicaid eligibility, including outreach through social media, video production, and other media platforms;

(vi) identify ways that the eligibility website for enrollment in CHIP and children's Medicaid can be redesigned to increase accessibility and enhance the user experience;

(vii) identify outreach opportunities, including partnerships with community organizations including:

(A) schools;

(B) small businesses;

(C) unemployment centers;

(D) parent-teacher associations; and

(E) youth athlete clubs and associations; and

(viii) develop messaging to increase awareness of coverage options that are available through the department.

(3) (a) The department may not delegate implementation of the program to a private

entity.

(b) Notwithstanding Subsection (3)(a), the department may contract with a media agency to conduct the activities described in Subsection (2)(b)(iv) and (vii).

Section 37. Section **26B-3-137**, which is renumbered from Section 26-18-28 is renumbered and amended to read:

[~~26-18-28~~]. 26B-3-137. Reimbursement for diabetes prevention program.

(1) As used in this section, "DPP" means the National Diabetes Prevention Program developed by the United States Centers for Disease Control and Prevention.

(2) Beginning July 1, 2022, the Medicaid program shall reimburse a provider for an enrollee's participation in the DPP if the enrollee:

(a) meets the DPP's eligibility requirements; and

(b) has not previously participated in the DPP after July 1, 2022, while enrolled in the Medicaid program.

(3) Subject to appropriation, the Medicaid program may set the rate for reimbursement.

(4) The department may apply for a state plan amendment if necessary to implement this section.

(5) (a) On or after July 1, 2025, but before October 1, 2025, the department shall provide a written report regarding the efficacy of the DPP and reimbursement under this section to the Health and Human Services Interim Committee.

(b) The report described in Subsection (5)(a) shall include:

(i) the total number of enrollees with a prediabetic condition as of July 1, 2022;

(ii) the total number of enrollees as of July 1, 2022, with a diagnosis of type 2 diabetes;

(iii) the total number of enrollees who participated in the DPP;

(iv) the total cost incurred by the state to implement this section; and

(v) any conclusions that can be drawn regarding the impact of the DPP on the rate of type 2 diabetes for enrollees.

Section 38. Section **26B-3-138**, which is renumbered from Section 26-18-427 is renumbered and amended to read:

[~~26-18-427~~]. 26B-3-138. Behavioral health delivery working group.

(1) As used in this section, "targeted adult Medicaid program" means the same as that term is defined in Section 26-18-411.

(2) On or before May 31, 2022, the department shall convene a working group to collaborate with the department on:

(a) establishing specific and measurable metrics regarding:

(i) compliance of managed care organizations in the state with federal Medicaid managed care requirements;

(ii) timeliness and accuracy of authorization and claims processing in accordance with Medicaid policy and contract requirements;

(iii) reimbursement by managed care organizations in the state to providers to maintain adequacy of access to care;

(iv) availability of care management services to meet the needs of Medicaid-eligible individuals enrolled in the plans of managed care organizations in the state; and

(v) timeliness of resolution for disputes between a managed care organization and the managed care organization's providers and enrollees;

(b) improving the delivery of behavioral health services in the Medicaid program;

(c) proposals to implement the delivery system adjustments authorized under Subsection 26-18-428(3); and

(d) issues that are identified by managed care organizations, behavioral health service providers, and the department.

(3) The working group convened under Subsection (2) shall:

(a) meet quarterly; and

(b) consist of at least the following individuals:

(i) the executive director or the executive director's designee;

(ii) for each Medicaid accountable care organization with which the department contracts, an individual selected by the accountable care organization;

(iii) five individuals selected by the department to represent various types of behavioral health services providers, including, at a minimum, individuals who represent providers who provide the following types of services:

(A) acute inpatient behavioral health treatment;

(B) residential treatment;

(C) intensive outpatient or partial hospitalization treatment; and

(D) general outpatient treatment;

(iv) a representative of an association that represents behavioral health treatment providers in the state, designated by the Utah Behavioral Healthcare Council convened by the Utah Association of Counties;

(v) a representative of an organization representing behavioral health organizations;

(vi) the chair of the Utah Substance Use and Mental Health Advisory Council created in Section 63M-7-301;

(vii) a representative of an association that represents local authorities who provide public behavioral health care, designated by the department;

(viii) one member of the Senate, appointed by the president of the Senate; and

(ix) one member of the House of Representatives, appointed by the speaker of the House of Representatives.

(4) The working group convened under this section shall recommend to the department:

(a) specific and measurable metrics under Subsection (2)(a);

(b) how physical and behavioral health services may be integrated for the targeted adult Medicaid program, including ways the department may address issues regarding:

(i) filing of claims;

(ii) authorization and reauthorization for treatment services;

(iii) reimbursement rates; and

(iv) other issues identified by the department, behavioral health services providers, or Medicaid managed care organizations;

(c) ways to improve delivery of behavioral health services to enrollees, including changes to statute or administrative rule; and

(d) wraparound service coverage for enrollees who need specific, nonclinical services to ensure a path to success.

Section 39. Section **26B-3-139**, which is renumbered from Section 26-18-603 is renumbered and amended to read:

[~~26-18-603~~]. 26B-3-139. Adjudicative proceedings related to Medicaid funds.

(1) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to recovery of Medicaid funds:

(a) the presiding officer shall be designated by the executive director of the department and report directly to the executive director or, in the discretion of the executive director, report directly to the director of the Office of Internal Audit; and

(b) the decision of the presiding officer is the recommended decision to the executive director of the department or a designee of the executive director who is not in the division.

(2) Subsection (1) does not apply to hearings conducted by the Department of Workforce Services relating to medical assistance eligibility determinations.

(3) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to Medicaid or Medicaid funds, the following may attend and present evidence or testimony at the proceeding:

(a) the director of the Office of Internal Audit, or the director's designee; and

(b) the inspector general of Medicaid services or the inspector general's designee.

(4) In relation to a proceeding of the department under Title 63G, Chapter 4, Administrative Procedures Act, a person may not, outside of the actual proceeding, attempt to influence the decision of the presiding officer.

Section 40. Section **26B-3-140**, which is renumbered from Section 26-18-604 is renumbered and amended to read:

[~~26-18-604~~]. 26B-3-140. Division duties -- Reporting.

(1) As used in this section:

(a) "Abuse" means:

(i) an action or practice that:

(A) is inconsistent with sound fiscal, business, or medical practices; and

(B) results, or may result, in unnecessary Medicaid related costs or other medical or hospital assistance costs; or

(ii) reckless or negligent upcoding.

(b) "Fraud" means intentional or knowing:

(i) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, claims, reimbursement, or practice; or

(ii) deception or misrepresentation in relation to medical or hospital assistance funds, costs, claims, reimbursement, or practice.

(c) "Upcoding" means assigning an inaccurate billing code for a service that is payable

or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.

(d) "Waste" means overutilization of resources or inappropriate payment.

(2) The division shall:

[~~(1)~~] (a) develop and implement procedures relating to Medicaid funds and medical or hospital assistance funds to ensure that providers do not receive:

[~~(a)~~] (i) duplicate payments for the same goods or services;

[~~(b)~~] (ii) payment for goods or services by resubmitting a claim for which:

[~~(i)~~] (A) payment has been disallowed on the grounds that payment would be a violation of federal or state law, administrative rule, or the state plan; and

[~~(ii)~~] (B) the decision to disallow the payment has become final;

[~~(c)~~] (iii) payment for goods or services provided after a recipient's death, including payment for pharmaceuticals or long-term care; or

[~~(d)~~] (iv) payment for transporting an unborn infant;

[~~(2)~~] (b) consult with [~~the Centers for Medicaid and Medicare Services~~] CMS, other states, and the Office of Inspector General of Medicaid Services to determine and implement best practices for discovering and eliminating fraud, waste, and abuse of Medicaid funds and medical or hospital assistance funds;

[~~(3)~~] (c) actively seek repayment from providers for improperly used or paid:

[~~(a)~~] (i) Medicaid funds; and

[~~(b)~~] (ii) medical or hospital assistance funds;

[~~(4)~~] (d) coordinate, track, and keep records of all division efforts to obtain repayment of the funds described in Subsection [~~(3)~~] (c), and the results of those efforts;

[~~(5)~~] (e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the pharmaceuticals that represent the highest 45% of state Medicaid expenditures for pharmaceuticals and on an annual basis for the remaining pharmaceuticals:

[~~(a)~~] (i) tracking changes in the price of pharmaceuticals;

[~~(b)~~] (ii) checking the availability and price of generic drugs;

[~~(c)~~] (iii) reviewing and updating the state's maximum allowable cost list; and

[~~(d)~~] (iv) comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists; and

[~~(6)~~] (f) provide training, on an annual basis, to the employees of the division who make decisions on billing codes, or who are in the best position to observe and identify upcoding, in order to avoid and detect upcoding.

Section 41. Section **26B-3-141**, which is renumbered from Section 26-18-703 is renumbered and amended to read:

[~~26-18-703~~]. 26B-3-141. Medical assistance from division or Department of Workforce Services and compliance under adoption assistance interstate compact -- Penalty for fraudulent claim.

(1) As used in this section:

(a) "Adoption assistance" means the same as that term is defined in Section 80-2-809.

(b) "Adoption assistance agreement" means the same as that term is defined in Section 80-2-809.

(c) "Adoption assistance interstate compact" means an agreement executed by the Division of Child and Family Services with any other state in accordance with Section 80-2-809.

[~~(1)~~] (2) (a) A child who is a resident of this state and is the subject of an adoption assistance interstate compact is entitled to receive medical assistance from the division and the Department of Workforce Services by filing a certified copy of the child's adoption assistance agreement with the division or the Department of Workforce Services.

(b) The adoptive parent of the child described in Subsection [~~(1)~~] (2)(a) shall annually provide the division or the Department of Workforce Services with evidence verifying that the adoption assistance agreement is still effective.

[~~(2)~~] (3) The Department of Workforce Services shall consider the recipient of medical assistance under this section as the Department of Workforce Services does any other recipient of medical assistance under an adoption assistance agreement executed by the Division of Child and Family Services.

[~~(3)~~] (4) (a) A person may not submit a claim for payment or reimbursement under this section that the person knows is false, misleading, or fraudulent.

(b) A violation of Subsection [~~(3)~~] (4)(a) is a third degree felony.

(5) The division and the Department of Workforce Services shall:

(a) cooperate with the Division of Child and Family Services in regards to an adoption assistance interstate compact; and

(b) comply with an adoption assistance interstate compact.

Section 42. Section **26B-3-201**, which is renumbered from Section 26-18-403 is renumbered and amended to read:

Part 2. Medicaid Waivers

[~~26-18-403~~]. 26B-3-201. Medicaid waiver for independent foster care adolescents.

(1) [~~For purposes of~~] As used in this section, an "independent foster care adolescent" includes any individual who reached 18 years of age while in the custody of the[~~Division of Child and Family Services, or the Department of Human Services~~] department if the [~~Division of Child and Family Services~~] department was the primary case manager, or a federally recognized Indian tribe.

(2) An independent foster care adolescent is eligible, when funds are available, for Medicaid coverage until the individual reaches 21 years of age.

(3) Before July 1, 2006, the division shall submit a state Medicaid Plan amendment to [~~the Center For Medicaid Services~~] CMS to provide medical coverage for independent foster care adolescents effective fiscal year 2006-07.

Section 43. Section **26B-3-202**, which is renumbered from Section 26-18-405 is renumbered and amended to read:

[~~26-18-405~~]. 26B-3-202. Waivers to maximize replacement of fee-for-service delivery model -- Cost of mandated program changes.

(1) The department shall develop a waiver program in the Medicaid program to replace the fee-for-service delivery model with one or more risk-based delivery models.

(2) The waiver program shall:

(a) restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the waiver program, maintain or improve recipient health status;

(b) restructure the program's cost sharing provisions and other incentives to reward

recipients for personal efforts to:

(i) maintain or improve their health status; and

(ii) use providers that deliver the most appropriate services at the lowest cost;

(c) identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that:

(i) pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter; and

(ii) reward providers for delivering services that make the most positive contribution to a recipient's health status;

(d) limit total annual per-patient-per-month expenditures for services delivered through fee-for-service arrangements to total annual per-patient-per-month expenditures for services delivered through risk-based arrangements covering similar recipient populations and services; and

(e) except as provided in Subsection (4), limit the rate of growth in per-patient-per-month General Fund expenditures for the program to the rate of growth in General Fund expenditures for all other programs, when the rate of growth in the General Fund expenditures for all other programs is greater than zero.

(3) To the extent possible, the department shall operate the waiver program with the input of stakeholder groups representing those who will be affected by the waiver program.

(4) (a) For purposes of this Subsection (4), "mandated program change" shall be determined by the department in consultation with the Medicaid accountable care organizations, and may include a change to the state Medicaid program that is required by state or federal law, state or federal guidance, policy, or the state Medicaid plan.

(b) A mandated program change shall be included in the base budget for the Medicaid program for the fiscal year in which the Medicaid program adopted the mandated program change.

(c) The mandated program change is not subject to the limit on the rate of growth in per-patient-per-month General Fund expenditures for the program established in Subsection (2)(e), until the fiscal year following the fiscal year in which the Medicaid program adopted the mandated program change.

(5) A managed care organization or a pharmacy benefit manager that provides a pharmacy benefit to an enrollee shall establish a unique group number, payment classification number, or bank identification number for each Medicaid managed care organization plan for which the managed care organization or pharmacy benefit manager provides a pharmacy benefit.

Section 44. Section **26B-3-203**, which is renumbered from Section 26-18-405.5 is renumbered and amended to read:

[~~26-18-405.5~~]. 26B-3-203. Base budget appropriations for Medicaid accountable care organizations and behavioral health plans -- Forecast of behavioral health services cost.

(1) As used in this section:

(a) "ACO" means an accountable care organization that contracts with the state's Medicaid program for:

(i) physical health services; or

(ii) integrated physical and behavioral health services.

(b) "Base budget" means the same as that term is defined in legislative rule.

(c) "Behavioral health plan" means a managed care or fee for service delivery system that contracts with or is operated by the department to provide behavioral health services to Medicaid eligible individuals.

(d) "Behavioral health services" means mental health or substance use treatment or services.

(e) "General Fund growth factor" means the amount determined by dividing the next fiscal year ongoing General Fund revenue estimate by current fiscal year ongoing appropriations from the General Fund.

(f) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal year ongoing General Fund revenue estimate identified by the Executive Appropriations Committee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal Analyst in preparing budget recommendations.

(g) "PMPM" means per-member-per-month funding.

(2) If the General Fund growth factor is less than 100%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the department in an

amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by 100%.

(3) If the General Fund growth factor is greater than or equal to 100%, but less than 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by the General Fund growth factor.

(4) If the General Fund growth factor is greater than or equal to 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health plans is greater than or equal to the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by 102% and less than or equal to the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by the General Fund growth factor.

(5) The appropriations provided to the department for behavioral health plans under this section shall be reduced by the amount contributed by counties in the current fiscal year for behavioral health plans in accordance with Subsections 17-43-201(5)(k) and 17-43-301(6)(a)(x).

(6) In order for the department to estimate the impact of Subsections (2) through (4) before identification of the next fiscal year ongoing General Fund revenue estimate, the Governor's Office of Planning and Budget shall, in cooperation with the Office of the Legislative Fiscal Analyst, develop an estimate of ongoing General Fund revenue for the next fiscal year and provide the estimate to the department no later than November 1 of each year.

(7) The Office of the Legislative Fiscal Analyst shall include an estimate of the cost of behavioral health services in any state Medicaid funding or savings forecast that is completed in coordination with the department and the Governor's Office of Planning and Budget.

Section 45. Section **26B-3-204**, which is renumbered from Section 26-18-408 is renumbered and amended to read:

[~~26-18-408~~]. 26B-3-204. Incentives to appropriately use emergency department services.

(1) (a) This section applies to the Medicaid program and to the Utah Children's Health

Insurance Program created in [~~Chapter 40, Utah Children's Health Insurance Act~~] Section 26B-3-XXX.

(b) As used in this section:

(i) "Managed care organization" means a comprehensive full risk managed care delivery system that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through a managed care plan.

(ii) "Managed care plan" means a risk-based delivery service model authorized by Section [~~26-18-405~~] 26B-3-XXX and administered by a managed care organization.

(iii) "Non-emergent care":

(A) means use of the emergency department to receive health care that is non-emergent as defined by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and the Emergency Medical Treatment and Active Labor Act; and

(B) does not mean the medical services provided to an individual required by the Emergency Medical Treatment and Active Labor Act, including services to conduct a medical screening examination to determine if the recipient has an emergent or non-emergent condition.

(iv) "Professional compensation" means payment made for services rendered to a Medicaid recipient by an individual licensed to provide health care services.

(v) "Super-utilizer" means a Medicaid recipient who has been identified by the recipient's managed care organization as a person who uses the emergency department excessively, as defined by the managed care organization.

(2) (a) A managed care organization may, in accordance with Subsections (2)(b) and (c):

(i) audit emergency department services provided to a recipient enrolled in the managed care plan to determine if non-emergent care was provided to the recipient; and

(ii) establish differential payment for emergent and non-emergent care provided in an emergency department.

(b) (i) The differential payments under Subsection (2)(a)(ii) do not apply to professional compensation for services rendered in an emergency department.

(ii) Except in cases of suspected fraud, waste, and abuse, a managed care organization's audit of payment under Subsection (2)(a)(i) is limited to the 18-month period of time after the

date on which the medical services were provided to the recipient. If fraud, waste, or abuse is alleged, the managed care organization's audit of payment under Subsection (2)(a)(i) is limited to three years after the date on which the medical services were provided to the recipient.

(c) The audits and differential payments under Subsections (2)(a) and (b) apply to services provided to a recipient on or after July 1, 2015.

(3) A managed care organization shall:

(a) use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all Medicaid or CHIP recipients enrolled in the managed care plan;

(b) provide viable alternatives for increasing primary care provider reimbursement rates to incentivize after hours primary care access for recipients; and

(c) report to the department on how the managed care organization complied with this Subsection (3).

(4) The department may:

(a) through administrative rule adopted by the department, develop quality measurements that evaluate a managed care organization's delivery of:

(i) appropriate emergency department services to recipients enrolled in the managed care plan;

(ii) expanded primary care and urgent care for recipients enrolled in the managed care plan, with consideration of the managed care organization's:

(A) delivery of primary care, urgent care, and after hours care through means other than the emergency department;

(B) recipient access to primary care providers and community health centers including evening and weekend access; and

(C) other innovations for expanding access to primary care; and

(iii) quality of care for the managed care plan members;

(b) compare the quality measures developed under Subsection (4)(a) for each managed care organization; and

(c) develop, by administrative rule, an algorithm to determine assignment of new, unassigned recipients to specific managed care plans based on the plan's performance in relation to the quality measures developed pursuant to Subsection (4)(a).

Section 46. Section **26B-3-205**, which is renumbered from Section 26-18-409 is renumbered and amended to read:

[~~26-18-409~~]. 26B-3-205. Long-term care insurance partnership.

(1) As used in this section:

(a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec. 7702B(b).

(b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec. 1396p(b)(1)(C)(iii).

(c) "State plan amendment" means an amendment to the state Medicaid plan drafted by the department in compliance with this section.

(2) No later than July 1, 2014, the department shall seek federal approval of a state plan amendment that creates a qualified long-term care insurance partnership.

(3) The department may make rules to comply with federal laws and regulations relating to qualified long-term care insurance partnerships and qualified long-term care insurance contracts.

Section 47. Section **26B-3-206**, which is renumbered from Section 26-18-410 is renumbered and amended to read:

[~~26-18-410~~]. 26B-3-206. Medicaid waiver for children with disabilities and complex medical needs.

(1) As used in this section:

(a) "Additional eligibility criteria" means the additional eligibility criteria set by the department under Subsection (4)(e).

(b) "Complex medical condition" means a physical condition of an individual that:

(i) results in severe functional limitations for the individual; and

(ii) is likely to:

(A) last at least 12 months; or

(B) result in death.

(c) "Program" means the program for children with complex medical conditions created in Subsection (3).

(d) "Qualified child" means a child who:

(i) is less than 19 years old;

(ii) is diagnosed with a complex medical condition;

(iii) has a condition that meets the definition of disability in 42 U.S.C. Sec. 12102; and

(iv) meets the additional eligibility criteria.

(2) The department shall apply for a Medicaid home and community-based waiver with CMS to implement, within the state Medicaid program, the program described in Subsection (3).

(3) If the waiver described in Subsection (2) is approved, the department shall offer a program that:

(a) as funding permits, provides treatment for qualified children;

(b) if approved by CMS and as funding permits, beginning in fiscal year 2023 provides on an ongoing basis treatment for 130 more qualified children than the program provided treatment for during fiscal year 2022; and

(c) accepts applications for the program on an ongoing basis.

(i) requires periodic reevaluations of an enrolled child's eligibility and other applicants or eligible children waiting for services in the program based on the additional eligibility criteria; and

(ii) at the time of reevaluation, allows the department to disenroll a child based on the prioritization described in Subsection (4)(a) and additional eligibility criteria.

(4) The department shall:

(a) establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, criteria to prioritize qualified children's participation in the program based on the following factors, in the following priority order:

(i) the complexity of a qualified child's medical condition; and

(ii) the financial needs of the qualified child and the qualified child's family;

(b) convene a public process to determine the benefits and services to offer a qualified child under the program;

(c) evaluate, on an ongoing basis, the cost and effectiveness of the program;

(d) if funding for the program is reduced, develop an evaluation process to reduce the number of children served based on the participation criteria established under Subsection (4)(a); and

(e) establish, by rule made in accordance with Title 63G, Chapter 3, Utah

Administrative Rulemaking Act, additional eligibility criteria based on the factors described in Subsections (4)(a)(i) and (ii).

Section 48. Section **26B-3-207**, which is renumbered from Section 26-18-411 is renumbered and amended to read:

[~~26-18-411~~]. 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 26-18-416.

(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 (10).

(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 abuse, 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 17-43-201.

(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 [~~26-18-428~~] 26B-3-224;

(ii) except as provided in Subsection (5)(b)(iii), for behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;

(iii) that, subject to Section [~~26-18-428~~] 26B-3-224, 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 abuse 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 abuse treatment or mental health treatment, as determined by the department; or

(iii) if funding is available, an individual in need of substance abuse 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.

(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) Before September 30 of each year, the department shall report to the Health and Human Services Interim Committee and to the Executive Appropriations Committee:

(a) the number of individuals who enrolled in Medicaid under Subsection (6);

(b) the state cost of providing Medicaid to individuals enrolled under Subsection (6); and

(c) recommendations for adjusting the income eligibility ceiling under Subsection (7), and other eligibility criteria under Subsection (6), for the upcoming fiscal year.

(9) 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.

(10) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to provide matching funds to the state for the cost of providing Medicaid services to newly enrolled individuals who qualify for Medicaid coverage under the health coverage improvement program under Subsection (6).

(11) 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 (11)(c).

(12) 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 49. Section **26B-3-208**, which is renumbered from Section 26-18-413 is renumbered and amended to read:

[~~26-18-413~~]. 26B-3-208. Medicaid waiver for delivery of adult dental services.

(1) (a) Before June 30, 2016, the department shall ask CMS to grant waivers from federal statutory and regulatory law necessary for the Medicaid program to provide dental services in the manner described in Subsection (2)(a).

(b) Before June 30, 2018, the department shall submit to CMS a request for waivers, or an amendment of existing waivers, from federal law necessary for the state to provide dental

services, in accordance with Subsections (2)(b)(i) and (d) through (g), to an individual described in Subsection (2)(b)(i).

(c) Before June 30, 2019, the department shall submit to the Centers for Medicare and Medicaid Services a request for waivers, or an amendment to existing waivers, from federal law necessary for the state to:

(i) provide dental services, in accordance with Subsections (2)(b)(ii) and (d) through (g) to an individual described in Subsection (2)(b)(ii); and

(ii) provide the services described in Subsection (2)(h).

(2) (a) To the extent funded, the department shall provide services to only blind or disabled individuals, as defined in 42 U.S.C. Sec. 1382c(a)(1), who are 18 years old or older and eligible for the program.

(b) Notwithstanding Subsection (2)(a):

(i) if a waiver is approved under Subsection (1)(b), the department shall provide dental services to an individual who:

(A) qualifies for the health coverage improvement program described in Section 26-18-411; and

(B) is receiving treatment in a substance abuse treatment program, as defined in Section [~~62A-2-101~~] 26B-2-101, licensed under [~~Title 62A, Chapter 2, Licensure of Programs and Facilities~~] Chapter 2, Part 1, Human Services Programs and Facilities; and

(ii) if a waiver is approved under Subsection (1)(c)(i), the department shall provide dental services to an individual who is an aged individual as defined in 42 U.S.C. Sec. 1382c(a)(1).

(c) To the extent possible, services to individuals described in Subsection (2)(a) shall be provided through the University of Utah School of Dentistry and the University of Utah School of Dentistry's associated statewide network.

(d) The department shall provide the services to individuals described in Subsection (2)(b):

(i) by contracting with an entity that:

(A) has demonstrated experience working with individuals who are being treated for both a substance use disorder and a major oral health disease;

(B) operates a program, targeted at the individuals described in Subsection (2)(b), that

has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals described in Subsection (2)(b);

(C) is willing to pay for an amount equal to the program's non-federal share of the cost of providing dental services to the population described in Subsection (2)(b); and

(D) is willing to pay all state costs associated with applying for the waiver described in Subsection (1)(b) and administering the program described in Subsection (2)(b); and

(ii) through a fee-for-service payment model.

(e) The entity that receives the contract under Subsection (2)(d)(i) shall cover all state costs of the program described in Subsection (2)(b).

(f) Each fiscal year, the University of Utah School of Dentistry shall, in compliance with state and federal regulations regarding intergovernmental transfers, transfer funds to the program in an amount equal to the program's non-federal share of the cost of providing services under this section through the school during the fiscal year.

(g) If a waiver is approved under Subsection (1)(c)(ii), the department shall provide coverage for porcelain and porcelain-to-metal crowns if the services are provided:

(i) to an individual who qualifies for dental services under Subsection (2)(b); and

(ii) by an entity that covers all state costs of:

(A) providing the coverage described in this Subsection (2)(h); and

(B) applying for the waiver described in Subsection (1)(c).

(h) Where possible, the department shall ensure that services described in Subsection (2)(a) that are not provided by the University of Utah School of Dentistry or the University of Utah School of Dentistry's associated network are provided:

(i) through fee for service reimbursement until July 1, 2018; and

(ii) after July 1, 2018, through the method of reimbursement used by the division for Medicaid dental benefits.

(i) Subject to appropriations by the Legislature, and as determined by the department, the scope, amount, duration, and frequency of services may be limited.

(3) (a) If the waivers requested under Subsection (1)(a) are granted, the Medicaid program shall begin providing dental services in the manner described in Subsection (2) no later than July 1, 2017.

(b) If the waivers requested under Subsection (1)(b) are granted, the Medicaid program

shall begin providing dental services to the population described in Subsection (2)(b) within 90 days from the day on which the waivers are granted.

(c) If the waivers requested under Subsection (1)(c)(i) are granted, the Medicaid program shall begin providing dental services to the population described in Subsection (2)(b)(ii) within 90 days after the day on which the waivers are granted.

(4) If the federal share of the cost of providing dental services under this section will be less than 65% during any portion of the next fiscal year, the Medicaid program shall cease providing dental services under this section no later than the end of the current fiscal year.

Section 50. Section **26B-3-209**, which is renumbered from Section 26-18-414 is renumbered and amended to read:

[~~26-18-414~~]. 26B-3-209. Medicaid long-term support services housing coordinator.

(1) There is created within the Medicaid program a full-time-equivalent position of Medicaid long-term support services housing coordinator.

(2) The coordinator shall help Medicaid recipients receive long-term support services in a home or other community-based setting rather than in a nursing home or other institutional setting by:

(a) working with municipalities, counties, the Housing and Community Development Division within the Department of Workforce Services, and others to identify community-based settings available to recipients;

(b) working with the same entities to promote the development, construction, and availability of additional community-based settings;

(c) training Medicaid case managers and support coordinators on how to help Medicaid recipients move from an institutional setting to a community-based setting; and

(d) performing other related duties.

Section 51. Section **26B-3-210**, which is renumbered from Section 26-18-415 is renumbered and amended to read:

[~~26-18-415~~]. 26B-3-210. Medicaid waiver expansion.

(1) As used in this section:

(a) "Federal poverty level" means the same as that term is defined in Section [~~26-18-411~~] 26B-3-207.

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

(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) 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(y) for enrolling an individual in the Medicaid program;

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

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

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

(vii) sunset in accordance with Subsection (5)(a); and

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

(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 Expansion Fund, created in Section [~~26-36b-208~~] 26B-X-XXX;

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

(b) As part of the provision described in Subsection (2)(b)(iv), 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); 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) (a) If federal financial participation for the Medicaid waiver expansion 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.

(b) 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.

(6) If the Medicaid waiver expansion is approved by CMS, the department shall report to the Social Services Appropriations Subcommittee on or before November 1 of each year that the Medicaid waiver expansion is operational:

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

(b) costs to the state for the Medicaid waiver program;

(c) estimated costs for the current and following state fiscal year; and

(d) recommendations to control costs of the Medicaid waiver expansion.

Section 52. Section **26B-3-211**, which is renumbered from Section 26-18-416 is renumbered and amended to read:

[~~26-18-416~~]. 26B-3-211. Primary Care Network enhancement waiver program.

(1) As used in this section:

(a) "Enhancement waiver program" means the Primary Care Network enhancement waiver program described in this section.

(b) "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. 9902(2).

(c) "Health coverage improvement program" means the same as that term is defined in Section 26-18-411.

(d) "Income eligibility ceiling" means the percentage of federal poverty level:

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

(ii) under which an individual may qualify for coverage in the enhancement waiver program in accordance with this section.

(e) "Optional population" means the optional expansion population under PPACA if the expansion provides coverage for individuals at or above 95% of the federal poverty level.

(f) "Primary Care Network" means the state Primary Care Network program created by the Medicaid primary care network demonstration waiver obtained under Section [~~26-18-3~~] 26B-3-108.

(2) The department shall continue to implement the Primary Care Network program for qualified individuals under the Primary Care Network program.

(3) (a) The division shall apply for a Medicaid waiver or a state plan amendment with CMS to implement, within the state Medicaid program, the enhancement waiver program described in this section within six months after the day on which:

(i) the division receives a notice from CMS that the waiver for the Medicaid waiver expansion submitted under Section [~~26-18-415~~] 26B-3-210, Medicaid waiver expansion, will not be approved; or

(ii) the division withdraws the waiver for the Medicaid waiver expansion submitted under Section [~~26-18-415~~] 26B-3-210, Medicaid waiver expansion.

(b) The division may not apply for a waiver under Subsection (3)(a) while a waiver request under Section [~~26-18-415~~] 26B-3-210, Medicaid waiver expansion, is pending with

CMS.

(4) An individual who is eligible for the enhancement waiver program may receive the following benefits under the enhancement waiver program:

(a) the benefits offered under the Primary Care Network program;

(b) diagnostic testing and procedures;

(c) medical specialty care;

(d) inpatient hospital services;

(e) outpatient hospital services;

(f) outpatient behavioral health care, including outpatient substance abuse care; and

(g) for an individual who qualifies for the health coverage improvement program, as approved by CMS, temporary residential treatment for substance abuse 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.

(5) An individual is eligible for the enhancement waiver program if, at the time of enrollment:

(a) the individual is qualified to enroll in the Primary Care Network or the health coverage improvement program;

(b) the individual's annual income is below the income eligibility ceiling established by the Legislature under Subsection (1)(d); and

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

(6) (a) Based on available funding and approval from CMS, the department shall determine the criteria for an individual to qualify for the enhancement waiver program, based on the following priority:

(i) adults in the expansion population, as defined in Section [~~26-18-411~~] 26B-3-207, who qualify for the health coverage improvement program;

(ii) adults with dependent children who qualify for the health coverage improvement program under Subsection [~~26-18-411~~] 26B-3-207(3);

(iii) adults with dependent children who do not qualify for the health coverage improvement program; and

(iv) if funding is available, adults without dependent children.

(b) The number of individuals enrolled in the enhancement waiver program may not exceed 105% of the number of individuals who were enrolled in the Primary Care Network on December 31, 2017.

(c) The department may only use appropriations from the Medicaid Expansion Fund created in Section [~~26-36b-208~~] 26B-1-XXX to fund the state portion of the enhancement waiver program.

(7) The department may request a modification of the income eligibility ceiling and the eligibility criteria under Subsection (6) from CMS each fiscal year based on enrollment in the enhancement waiver program, projected enrollment in the enhancement waiver program, costs to the state, and the state budget.

(8) The department may implement the enhancement waiver program by contracting with Medicaid accountable care organizations to administer the enhancement waiver program.

(9) In accordance with Subsections [~~26-18-411~~] 26B-3-207(11) and (12), the department may use funds that have been appropriated for the health coverage improvement program to implement the enhancement waiver program.

(10) If the department expands the state Medicaid program to the optional population, the department:

(a) except as provided in Subsection (11), may not accept any new enrollees into the enhancement waiver program after the day on which the expansion to the optional population is effective;

(b) shall suspend the enhancement waiver program within one year after the day on which the expansion to the optional population is effective; and

(c) shall work with CMS to maintain the waiver for the enhancement waiver program submitted under Subsection (3) while the enhancement waiver program is suspended under Subsection (10)(b).

(11) If, after the expansion to the optional population described in Subsection (10) takes effect, the expansion to the optional population is repealed by either the state or the federal government, the department shall reinstate the enhancement waiver program and continue to accept new enrollees into the enhancement waiver program in accordance with the provisions of this section.

Section 53. Section **26B-3-212**, which is renumbered from Section 26-18-417 is

renumbered and amended to read:

[~~26-18-417~~]. 26B-3-212. Limited family planning services for low-income individuals.

(1) As used in this section:

(a) (i) "Family planning services" means family planning services that are provided under the state Medicaid program, including:

(A) sexual health education and family planning counseling; and

(B) other medical diagnosis, treatment, or preventative care routinely provided as part of a family planning service visit.

(ii) "Family planning services" do not include an abortion, as that term is defined in Section 76-7-301.

(b) "Low-income individual" means an individual who:

(i) has an income level that is equal to or below 95% of the federal poverty level; and

(ii) does not qualify for full coverage under the Medicaid program.

(2) Before July 1, 2018, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to:

(a) offer a program that provides family planning services to low-income individuals; and

(b) receive a federal match rate of 90% of state expenditures for family planning services provided under the waiver or state plan amendment.

Section 54. Section **26B-3-213**, which is renumbered from Section 26-18-418 is renumbered and amended to read:

[~~26-18-418~~]. 26B-3-213. Medicaid waiver for mental health crisis lines and mobile crisis outreach teams.

(1) As used in this section:

(a) "Local mental health crisis line" means the same as that term is defined in Section [~~62A-15-1301~~] 26B-X-XXX.

(b) "Mental health crisis" means:

(i) a mental health condition that manifests itself in an individual by symptoms of sufficient severity that a prudent layperson who possesses an average knowledge of mental health issues could reasonably expect the absence of immediate attention or intervention to

result in:

(A) serious danger to the individual's health or well-being; or

(B) a danger to the health or well-being of others; or

(ii) a mental health condition that, in the opinion of a mental health therapist or the therapist's designee, requires direct professional observation or the intervention of a mental health therapist.

(c) (i) "Mental health crisis services" means direct mental health services and on-site intervention that a mobile crisis outreach team provides to an individual suffering from a mental health crisis, including the provision of safety and care plans, prolonged mental health services for up to 90 days, and referrals to other community resources.

(ii) "Mental health crisis services" includes:

(A) local mental health crisis lines; and

(B) the statewide mental health crisis line.

(d) "Mental health therapist" means the same as that term is defined in Section 58-60-102.

(e) "Mobile crisis outreach team" or "MCOT" means a mobile team of medical and mental health professionals that, in coordination with local law enforcement and emergency medical service personnel, provides mental health crisis services.

(f) "Statewide mental health crisis line" means the same as that term is defined in Section [~~62A-15-1301~~] 26B-X-XXX.

(2) In consultation with the Department of Human Services and the Behavioral Health Crisis Response Commission created in Section 63C-18-202, the department shall develop a proposal to amend the state Medicaid plan to include mental health crisis services, including the statewide mental health crisis line, local mental health crisis lines, and mobile crisis outreach teams.

(3) By January 1, 2019, the department shall apply for a Medicaid waiver with CMS, if necessary to implement, within the state Medicaid program, the mental health crisis services described in Subsection (2).

Section 55. Section **26B-3-214**, which is renumbered from Section 26-18-419 is renumbered and amended to read:

[~~26-18-419~~]. 26B-3-214. Medicaid waiver for coverage of mental health

services in schools.

(1) As used in this section, "local education agency" means:

(a) a school district;

(b) a charter school; or

(c) the Utah Schools for the Deaf and the Blind.

(2) In consultation with the Department of Human Services and the State Board of Education, the department shall develop a proposal to allow the state Medicaid program to reimburse a local education agency, a local mental health authority, or a private provider for covered mental health services provided:

(a) in accordance with Section 53E-9-203; and

(b) (i) at a local education agency building or facility; or

(ii) by an employee or contractor of a local education agency.

(3) Before January 1, 2020, the department shall apply to CMS for a state plan amendment to implement the coverage described in Subsection (2).

Section 56. Section **26B-3-215**, which is renumbered from Section 26-18-420 is renumbered and amended to read:

[~~26-18-420~~]. 26B-3-215. Coverage for in vitro fertilization and genetic testing.

(1) As used in this section:

(a) "Qualified condition" means:

(i) cystic fibrosis;

(ii) spinal muscular atrophy;

(iii) Morquio Syndrome;

(iv) myotonic dystrophy; or

(v) sickle cell anemia.

(b) "Qualified enrollee" means an individual who:

(i) is enrolled in the Medicaid program;

(ii) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and

(iii) intends to get pregnant with a partner who is diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual.

(2) Before January 1, 2021, the department shall apply for a Medicaid waiver or a state plan amendment with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement the coverage described in Subsection (3).

(3) If the waiver described in Subsection (2) is approved, the Medicaid program shall provide coverage to a qualified enrollee for:

(a) in vitro fertilization services; and

(b) genetic testing of a qualified enrollee who receives in vitro fertilization services under Subsection (3)(a).

(4) The Medicaid program may not provide the coverage described in Subsection (3) before the later of:

(a) the day on which the waiver described in Subsection (2) is approved; and

(b) January 1, 2021.

(5) Before November 1, 2022, and before November 1 of every third year thereafter, the department shall:

(a) calculate the change in state spending attributable to the coverage under this section; and

(b) report the amount described in Subsection (4)(a) to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee.

Section 57. Section **26B-3-216**, which is renumbered from Section 26-18-420.1 is renumbered and amended to read:

[~~26-18-420.1~~]. 26B-3-216. Medicaid waiver for fertility preservation services.

(1) As used in this section:

(a) "Iatrogenic infertility" means an impairment of fertility or reproductive functioning caused by surgery, chemotherapy, radiation, or other medical treatment.

(b) "Physician" means an individual licensed to practice under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(c) "Qualified enrollee" means an individual who:

(i) is enrolled in the Medicaid program;

(ii) has been diagnosed with a form of cancer by a physician; and

(iii) needs treatment for that cancer that may cause a substantial risk of sterility or iatrogenic infertility, including surgery, radiation, or chemotherapy.

(d) "Standard fertility preservation service" means a fertility preservation procedure and service that:

(i) is not considered experimental or investigational by the American Society for Reproductive Medicine or the American Society of Clinical Oncology; and

(ii) is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, including:

(A) sperm banking;

(B) oocyte banking;

(C) embryo banking;

(D) banking of reproductive tissues; and

(E) storage of reproductive cells and tissues.

(2) Before January 1, 2022, the department shall apply for a Medicaid waiver or a state plan amendment with CMS to implement the coverage described in Subsection (3).

(3) If the waiver or state plan amendment described in Subsection (2) is approved, the Medicaid program shall provide coverage to a qualified enrollee for standard fertility preservation services.

(4) The Medicaid program may not provide the coverage described in Subsection (3) before the later of:

(a) the day on which the waiver described in Subsection (2) is approved; and

(b) January 1, 2023.

(5) Before November 1, 2023, and before November 1 of each third year after 2023, the department shall:

(a) calculate the change in state spending attributable to the coverage described in this section; and

(b) report the amount described in Subsection (5)(a) to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee.

Section 58. Section **26B-3-217**, which is renumbered from Section 26-18-421 is renumbered and amended to read:

[~~26-18-421~~]. 26B-3-217. Medicaid waiver for coverage of qualified inmates leaving prison or jail.

(1) As used in this section:

(a) "Correctional facility" means:

(i) a county jail;

(ii) the Department of Corrections, created in Section 64-13-2; or

(iii) a prison, penitentiary, or other institution operated by or under contract with the Department of Corrections for the confinement of an offender, as defined in Section 64-13-1.

(b) "Qualified inmate" means an individual who:

(i) is incarcerated in a correctional facility; and

(ii) has:

(A) a chronic physical or behavioral health condition;

(B) a mental illness, as defined in Section [~~62A-15-602~~] 26B-4-301; or

(C) an opioid use disorder.

(2) Before July 1, 2020, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to offer a program to provide Medicaid coverage to a qualified inmate for up to 30 days immediately before the day on which the qualified inmate is released from a correctional facility.

(3) If the waiver or state plan amendment described in Subsection (2) is approved, the department shall report to the Health and Human Services Interim Committee each year before November 30 while the waiver or state plan amendment is in effect regarding:

(a) the number of qualified inmates served under the program;

(b) the cost of the program; and

(c) the effectiveness of the program, including:

(i) any reduction in the number of emergency room visits or hospitalizations by inmates after release from a correctional facility;

(ii) any reduction in the number of inmates undergoing inpatient treatment after release from a correctional facility;

(iii) any reduction in overdose rates and deaths of inmates after release from a correctional facility; and

(iv) any other costs or benefits as a result of the program.

(4) If the waiver or state plan amendment described in Subsection (2) is approved, a county that is responsible for the cost of a qualified inmate's medical care shall provide the required matching funds to the state for:

(a) any costs to enroll the qualified inmate for the Medicaid coverage described in Subsection (2);

(b) any administrative fees for the Medicaid coverage described in Subsection (2); and

(c) the Medicaid coverage that is provided to the qualified inmate under Subsection (2).

Section 59. Section **26B-3-218**, which is renumbered from Section 26-18-422 is renumbered and amended to read:

[~~26-18-422~~]. 26B-3-218. Medicaid waiver for inpatient care in an institution for mental diseases.

(1) As used in this section, "institution for mental diseases" means the same as that term is defined in 42 C.F.R. Sec. 435.1010.

(2) Before August 1, 2020, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to offer a program that provides reimbursement for mental health services that are provided:

(a) in an institution for mental diseases that includes more than 16 beds; and

(b) to an individual who receives mental health services in an institution for mental diseases for a period of more than 15 days in a calendar month.

(3) If the waiver or state plan amendment described in Subsection (2) is approved, the department shall:

(a) [~~coordinate with the Department of Human Services to~~] develop and offer the program described in Subsection (2); and

(b) submit to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee any report that the department submits to CMS that relates to the budget neutrality, independent waiver evaluation, or performance metrics of the program described in Subsection (2), within 15 days after the day on which the report is submitted to CMS.

(4) Notwithstanding Sections 17-43-201 and 17-43-301, if the waiver or state plan amendment described in Subsection (2) is approved, a county does not have to provide

matching funds to the state for the mental health services described in Subsection (2) that are provided to an individual who qualifies for Medicaid coverage under Section [~~26-18-3.9 or Section 26-18-411~~] 26B-3-113 or 26B-3-207.

Section 60. Section **26B-3-219**, which is renumbered from Section 26-18-423 is renumbered and amended to read:

[~~26-18-423~~]. 26B-3-219. Reimbursement for crisis management services provided in a behavioral health receiving center -- Integration of payment for physical health services.

(1) As used in this section:

(a) "Accountable care organization" means the same as that term is defined in Section [~~26-18-408~~] 26B-3-204.

(b) "Behavioral health receiving center" means the same as that term is defined in Section [~~62A-15-118~~] 26B-4-114.

(c) "Crisis management services" means behavioral health services provided to an individual who is experiencing a mental health crisis.

(d) "Managed care organization" means the same as that term is defined in 42 C.F.R. Sec. 438.2.

(2) Before July 1, 2020, the division shall apply for a Medicaid waiver or state plan amendment with CMS to offer a program that provides reimbursement through a bundled daily rate for crisis management services that are delivered to an individual during the individual's stay at a behavioral health receiving center.

(3) If the waiver or state plan amendment described in Subsection (2) is approved, the department shall:

(a) implement the program described in Subsection (2); and

(b) require a managed care organization that contracts with the state's Medicaid program for behavioral health services or integrated health services to provide coverage for crisis management services that are delivered to an individual during the individual's stay at a behavioral health receiving center.

(4) (a) The department may elect to integrate payment for physical health services provided in a behavioral health receiving center.

(b) In determining whether to integrate payment under Subsection (4)(a), the

department shall consult with accountable care organizations and counties in the state.

Section 61. Section **26B-3-220**, which is renumbered from Section 26-18-424 is renumbered and amended to read:

[~~26-18-424~~]. 26B-3-220. Crisis services -- Reimbursement.

The Department shall submit a waiver or state plan amendment to allow for reimbursement for 988 services provided to an individual who is eligible and enrolled in Medicaid at the time this service is provided.

Section 62. Section **26B-3-221**, which is renumbered from Section 26-18-425 is renumbered and amended to read:

[~~26-18-425~~]. 26B-3-221. Medicaid waiver for respite care facility that provides services to homeless individuals.

(1) As used in this section:

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

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

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

(b) "Homeless" means the same as that term is defined in Section [~~26-18-411~~] 26B-3-207.

(c) "Medical respite care" means short-term housing with supportive medical services.

(d) "Medical respite facility" means a residential facility that provides medical respite care to homeless individuals.

(2) Before January 1, 2022, the department shall apply for a Medicaid waiver or state plan amendment with CMS to choose a single medical respite facility to reimburse for services provided to an individual who is:

(a) homeless; and

(b) an adult in the expansion population.

(3) The department shall choose a medical respite facility best able to serve homeless individuals who are adults in the expansion population.

(4) If the waiver or state plan amendment described in Subsection (2) is approved, while the waiver or state plan amendment is in effect, the department shall submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:

(a) the number of homeless individuals served at the facility;

(b) the cost of the program; and

(c) the reduction of health care costs due to the program's implementation.

(5) Through administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall further define and limit the services, described in this section, provided to a homeless individual.

Section 63. Section **26B-3-222**, which is renumbered from Section 26-18-426 is renumbered and amended to read:

[~~26-18-426~~]. 26B-3-222. Medicaid waiver expansion for extraordinary care reimbursement.

(1) As used in this section:

(a) "Existing home and community-based services waiver" means an existing home and community-based services waiver in the state that serves an individual:

(i) with an acquired brain injury;

(ii) with an intellectual or physical disability; or

(iii) who is 65 years old or older.

(b) "Personal care services" means a service that:

(i) is furnished to an individual who is not an inpatient nor a resident of a hospital, nursing facility, intermediate care facility, or institution for mental diseases;

(ii) is authorized for an individual described in Subsection (1)(b)(i) in accordance with a plan of treatment;

(iii) is provided by an individual who is qualified to provide the services; and

(iv) is furnished in a home or another community-based setting.

(c) "Waiver enrollee" means an individual who is enrolled in an existing home and community-based services waiver.

(2) Before July 1, 2021, the department shall apply with CMS for an amendment to an existing home and community-based services waiver to implement a program to offer reimbursement to an individual who provides personal care services that constitute extraordinary care to a waiver enrollee who is the individual's spouse.

(3) If CMS approves the amendment described in Subsection (2), the department shall implement the program described in Subsection (2).

(4) The department shall by rule, made in accordance with Title 63G, Chapter 3, Utah

Administrative Rulemaking Act, define "extraordinary care" for purposes of Subsection (2).

Section 64. Section **26B-3-223**, which is renumbered from Section 26-18-428 is renumbered and amended to read:

[~~26-18-428~~]. 26B-3-223. Delivery system adjustments for the targeted adult Medicaid program.

(1) As used in this section, "targeted adult Medicaid program" means the same as that term is defined in Section [~~26-18-411~~] 26B-3-207.

(2) The department may implement the delivery system adjustments authorized under Subsection (3) only on the later of:

(a) July 1, 2023; and

(b) the department determining that the Medicaid program, including providers and managed care organizations, are satisfying the metrics established in collaboration with the working group convened under Subsection [~~26-18-427~~] 26B-3-138(2).

(3) The department may, for individuals who are enrolled in the targeted adult Medicaid program:

(a) integrate the delivery of behavioral and physical health in certain counties; and

(b) deliver behavioral health services through an accountable care organization where implemented.

(4) Before implementing the delivery system adjustments described in Subsection (3) in a county, the department shall, at a minimum, seek input from:

(a) individuals who qualify for the targeted adult Medicaid program who reside in the county;

(b) the county's executive officer, legislative body, and other county officials who are involved in the delivery of behavioral health services;

(c) the local mental health authority and substance use authority that serves the county;

(d) Medicaid managed care organizations operating in the state, including Medicaid accountable care organizations;

(e) providers of physical or behavioral health services in the county who provide services to enrollees in the targeted adult Medicaid program in the county; and

(f) other individuals that the department deems necessary.

(5) If the department provides Medicaid coverage through a managed care delivery

system under this section, the department shall include language in the department's managed care contracts that require the managed care plan to:

(a) be in compliance with federal Medicaid managed care requirements;

(b) timely and accurately process authorizations and claims in accordance with Medicaid policy and contract requirements;

(c) adequately reimburse providers to maintain adequacy of access to care;

(d) provide care management services sufficient to meet the needs of Medicaid eligible individuals enrolled in the managed care plan's plan; and

(e) timely resolve any disputes between a provider or enrollee with the managed care plan.

(6) The department may take corrective action if the managed care organization fails to comply with the terms of the managed care organization's contract.

Section 65. Section **26B-3-224**, which is renumbered from Section 26-18-429 is renumbered and amended to read:

[~~26-18-429~~]. 26B-3-224. Medicaid waiver for increased integrated health care reimbursement.

(1) As used in this section:

(a) "Integrated health care setting" means a health care or behavioral health care setting that provides integrated physical and behavioral health care services.

(b) "Local mental health authority" means a local mental health authority described in Section 17-43-301.

(2) The department shall develop a proposal to allow the state Medicaid program to reimburse a local mental health authority for covered physical health care services provided in an integrated health care setting to Medicaid eligible individuals.

(3) Before December 31, 2022, the department shall apply for a Medicaid waiver or a state plan amendment with CMS to implement the proposal described in Subsection (2).

(4) If the waiver or state plan amendment described in Subsection (3) is approved, the department shall:

(a) implement the proposal described in Subsection (2); and

(b) while the waiver or state plan amendment is in effect, submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:

(i) the number of patients served under the waiver or state plan amendment;

(ii) the cost of the waiver or state plan amendment; and

(iii) any benefits of the waiver or state plan amendment.

Section 66. Section **26B-3-301**, which is renumbered from Section 26-18-101 is renumbered and amended to read:

Part 3. Administration of Medicaid Programs: Drug Utilization Review and Long Term Care Facility Certification

[~~26-18-101~~]. 26B-3-301. Definitions.

As used in this part:

(1) "Appropriate and medically necessary" means, regarding drug prescribing, dispensing, and patient usage, that it is in conformity with the criteria and standards developed in accordance with this part.

(2) "Board" means the Drug Utilization Review Board created in Section 26-18-102.

(3) "Certified program" means a nursing care facility program with Medicaid certification.

[~~(3)~~] (4) "Compendia" means resources widely accepted by the medical profession in the efficacious use of drugs, including "American Hospital Formulary Services Drug Information," "U.S. Pharmacopeia - Drug Information," "A.M.A. Drug Evaluations," peer-reviewed medical literature, and information provided by manufacturers of drug products.

[~~(4)~~] (5) "Counseling" means the activities conducted by a pharmacist to inform Medicaid recipients about the proper use of drugs, as required by the board under this part.

[~~(5)~~] (6) "Criteria" means those predetermined and explicitly accepted elements used to measure drug use on an ongoing basis in order to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

[~~(6)~~] (7) "Drug-disease contraindications" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.

[~~(7)~~] (8) "Drug-interactions" means that two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present, or that leads to interference with the effectiveness of one or any of the drugs.

[~~(8)~~] (9) "Drug Utilization Review" or "DUR" means the program designed to measure and assess, on a retrospective and prospective basis, the proper use of outpatient drugs in the

Medicaid program.

[~~(9)~~] (10) "Intervention" means a form of communication utilized by the board with a prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

(11) "Medicaid certification" means the right of a nursing care facility, as a provider of a nursing care facility program, to receive Medicaid reimbursement for a specified number of beds within the facility.

(12) (a) "Nursing care facility" means the following facilities licensed by the department under Chapter 2, Part 2, Health Care Facility Licensing and Inspection:

(i) skilled nursing facilities;

(ii) intermediate care facilities; and

(iii) an intermediate care facility for people with an intellectual disability.

(b) "Nursing care facility" does not mean a critical access hospital that meets the criteria of 42 U.S.C. 1395i-4(c)(2) (1998).

(13) "Nursing care facility program" means the personnel, licenses, services, contracts and all other requirements that shall be met for a nursing care facility to be eligible for Medicaid certification under this part and division rule.

[~~(10)~~] (14) "Overutilization" or "underutilization" means the use of a drug in such quantities that the desired therapeutic goal is not achieved.

[~~(11)~~] (15) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act.

(16) "Physical facility" means the buildings or other physical structures where a nursing care facility program is operated.

[~~(12)~~] (17) "Physician" means a person licensed in this state to practice medicine and surgery under Section 58-67-301 or osteopathic medicine under Section 58-68-301.

[~~(13)~~] (18) "Prospective DUR" means that part of the drug utilization review program that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy problems based on explicit and predetermined criteria and standards.

[~~(14)~~] (19) "Retrospective DUR" means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug use data against predetermined and explicit criteria and standards, on an ongoing basis with professional input.

(20) "Rural county" means a county with a population of less than 50,000, as determined by:

(a) the most recent official census or census estimate of the United States Bureau of the Census; or

(b) the most recent population estimate for the county from the Utah Population Committee, if a population figure for the county is not available under Subsection (7)(a).

(21) "Service area" means the boundaries of the distinct geographic area served by a certified program as determined by the division in accordance with this part and division rule.

[~~(15)~~] (22) "Standards" means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the Medicaid recipient database.

[~~(16)~~] (23) "SURS" means the Surveillance Utilization Review System of the Medicaid program.

[~~(17)~~] (24) "Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.

[~~(18)~~] (25) "Therapeutic duplication" means prescribing and dispensing the same drug or two or more drugs from the same therapeutic class where periods of drug administration overlap and where that practice is not medically indicated.

(26) "Urban county" means a county that is not a rural county.

Section 67. Section **26B-3-302**, which is renumbered from Section 26-18-102 is renumbered and amended to read:

[~~26-18-102~~]. 26B-3-302. DUR Board -- Creation and membership -- Expenses.

(1) There is created a 12-member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.

(2) (a) Except as required by Subsection (2)(b), as terms of current board members expire, the executive director shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (2)(a), the executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(c) Persons appointed to the board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms.

(d) The executive director shall provide for geographic balance in representation on the board.

(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(4) The membership shall be comprised of the following:

(a) four physicians who are actively engaged in the practice of medicine or osteopathic medicine in this state, to be selected from a list of nominees provided by the Utah Medical Association;

(b) one physician in this state who is actively engaged in academic medicine;

(c) three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the Utah Pharmaceutical Association;

(d) one pharmacist who is actively engaged in academic pharmacy;

(e) one person who shall represent consumers;

(f) one person who shall represent pharmaceutical manufacturers, to be recommended by the Pharmaceutical Manufacturers Association; and

(g) one dentist licensed to practice in this state under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act, who is actively engaged in the practice of dentistry, nominated by the Utah Dental Association.

(5) Physician and pharmacist members of the board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.

(6) The board shall elect a chair from among its members who shall serve a one-year term, and may serve consecutive terms.

(7) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Section 68. Section **26B-3-303**, which is renumbered from Section 26-18-103 is

renumbered and amended to read:

[~~26-18-103~~]. 26B-3-303. DUR Board -- Responsibilities.

The board shall:

(1) develop rules necessary to carry out its responsibilities as defined in this part;

(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;

(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:

(a) therapeutic appropriateness;

(b) overutilization or underutilization;

(c) therapeutic duplication;

(d) drug-disease contraindications;

(e) drug-drug interactions;

(f) incorrect drug dosage or duration of drug treatment; and

(g) clinical abuse and misuse;

(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;

(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;

(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;

(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;

(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;

(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;

(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;

(11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec. 712;

(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;

(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63G, Chapter 4, Administrative Procedures Act;

(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:

(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;

(b) potential or actual severe or adverse reactions to drugs;

(c) therapeutic appropriateness;

(d) overutilization or underutilization;

(e) appropriate use of generics;

(f) therapeutic duplication;

(g) drug-disease contraindications;

(h) drug-drug interactions;

(i) incorrect drug dosage and duration of drug treatment;

(j) drug allergy interactions; and

(k) clinical abuse and misuse;

(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the

refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:

(a) the name and description of the medication;

(b) administration, form, and duration of therapy;

(c) special directions and precautions for use;

(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;

(e) techniques for self-monitoring drug therapy;

(f) proper storage;

(g) prescription refill information; and

(h) action to be taken in the event of a missed dose; and

(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:

(a) the name, address, age, and gender of the recipient;

(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;

(c) the pharmacist's comments on the individual's drug therapy;

(d) name of prescriber; and

(e) name of drug, dose, duration of therapy, and directions for use.

Section 69. Section **26B-3-304**, which is renumbered from Section 26-18-104 is renumbered and amended to read:

[~~26-18-104~~]. 26B-3-304. Confidentiality of records.

(1) Information obtained under this part shall be treated as confidential or controlled information under Title 63G, Chapter 2, Government Records Access and Management Act.

(2) The board shall establish procedures insuring that the information described in Subsection [~~26-18-103~~] 26B-3-303(16) is held confidential by the pharmacist, being provided to the physician only upon request.

(3) The board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program, that identifies individual

physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the board. The board may release cumulative nonidentifying information for research purposes.

Section 70. Section **26B-3-305**, which is renumbered from Section 26-18-105 is renumbered and amended to read:

[~~26-18-105~~]. 26B-3-305. Drug prior approval program.

(1) A drug prior approval program approved or implemented by the board shall meet the following conditions:

(a) except as provided in Subsection (2), a drug may not be placed on prior approval for other than medical reasons;

(b) the board shall hold a public hearing at least 30 days prior to placing a drug on prior approval;

(c) notwithstanding the provisions of Section 52-4-202, the board shall provide not less than 14 days' notice to the public before holding a public hearing under Subsection (1)(b);

(d) the board shall consider written and oral comments submitted by interested parties prior to or during the hearing held in accordance with Subsection (1)(b);

(e) the board shall provide evidence that placing a drug class on prior approval:

(i) will not impede quality of recipient care; and

(ii) that the drug class is subject to clinical abuse or misuse;

(f) the board shall reconsider its decision to place a drug on prior approval:

(i) no later than nine months after any drug class is placed on prior approval; and

(ii) at a public hearing with notice as provided in Subsection (1)(b);

(g) the program shall provide an approval or denial of a request for prior approval:

(i) by either:

(A) fax;

(B) telephone; or

(C) electronic transmission;

(ii) at least Monday through Friday, except for state holidays; and

(iii) within 24 hours after receipt of the prior approval request;

(h) the program shall provide for the dispensing of at least a 72-hour supply of the drug

on the prior approval program:

(i) in an emergency situation; or

(ii) on weekends or state holidays;

(i) the program may be applied to allow acceptable medical use of a drug on prior approval for appropriate off-label indications; and

(j) before placing a drug class on the prior approval program, the board shall:

(i) determine that the requirements of Subsections (1)(a) through (i) have been met; and

(ii) by majority vote, place the drug class on prior approval.

(2) The board may, only after complying with Subsections (1)(b) through (j), consider the cost:

(a) of a drug when placing a drug on the prior approval program; and

(b) associated with including, or excluding a drug from the prior approval process, including:

(i) potential side effects associated with a drug; or

(ii) potential hospitalizations or other complications that may occur as a result of a drug's inclusion on the prior approval process.

Section 71. Section **26B-3-306**, which is renumbered from Section 26-18-106 is renumbered and amended to read:

[~~26-18-106~~]. 26B-3-306. Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under [~~this part~~] Sections 26B-3-302 through 26B-3-309.

Section 72. Section **26B-3-307**, which is renumbered from Section 26-18-107 is renumbered and amended to read:

[~~26-18-107~~]. 26B-3-307. Retrospective and prospective DUR.

(1) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(2) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (3) and (4).

(3) The retrospective DUR program shall be based on guidelines established by the board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to:

(a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and

(b) assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:

(i) therapeutic appropriateness;

(ii) overutilization or underutilization;

(iii) therapeutic duplication;

(iv) drug-disease contraindications;

(v) drug-drug interactions;

(vi) incorrect drug dosage or duration of drug treatment; and

(vii) clinical abuse and misuse.

(4) The prospective DUR program shall be based on guidelines established by the board and shall provide that, before a prescription is filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:

(a) therapeutic duplication;

(b) drug-drug interactions;

(c) incorrect dosage or duration of treatment;

(d) drug-allergy interactions; and

(e) clinical abuse or misuse.

(5) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician or physician assistant. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

Section 73. Section **26B-3-308**, which is renumbered from Section 26-18-108 is renumbered and amended to read:

[~~26-18-108~~]. 26B-3-308. Penalties.

Any person who violates the confidentiality provisions of [~~this part~~] Sections 26B-3-302 through 26B-3-307 is guilty of a class B misdemeanor.

Section 74. Section **26B-3-309**, which is renumbered from Section 26-18-109 is renumbered and amended to read:

[~~26-18-109~~]. 26B-3-309. Immunity.

There is no liability on the part of, and no cause of action of any nature arises against any member of the board, its agents, or employees for any action or omission by them in effecting the provisions of [~~this part~~] Sections 26B-3-302 through 26B-3-307.

Section 75. Section **26B-3-310**, which is renumbered from Section 26-18-502 is renumbered and amended to read:

[~~26-18-502~~]. 26B-3-310. Purpose -- Medicaid certification of nursing care facilities.

(1) The Legislature finds:

(a) that an oversupply of nursing care facilities in the state adversely affects the state Medicaid program and the health of the people in the state;

(b) it is in the best interest of the state to prohibit nursing care facilities from receiving Medicaid certification, except as provided by [~~this part~~] Sections 26B-3-311 through 26B-3-313; and

(c) it is in the best interest of the state to encourage aging nursing care facilities with Medicaid certification to renovate the nursing care facilities' physical facilities so that the quality of life and clinical services for Medicaid residents are preserved.

(2) Medicaid reimbursement of nursing care facility programs is limited to:

(a) the number of nursing care facility programs with Medicaid certification as of May 9, 2016; and

(b) additional nursing care facility programs approved for Medicaid certification under the provisions of Subsections 26-18-503(5) and (7).

(3) The division may not:

(a) except as authorized by Section 26-18-503:

(i) process initial applications for Medicaid certification or execute provider agreements with nursing care facility programs; or

(ii) reinstate Medicaid certification for a nursing care facility whose certification expired or was terminated by action of the federal or state government; or

(b) execute a Medicaid provider agreement with a certified program that moves to a

different physical facility, except as authorized by Subsection 26-18-503(3).

(4) Notwithstanding Section 26-18-503, beginning May 4, 2021, the division may not approve a new or additional bed in an intermediate care facility for individuals with an intellectual disability for Medicaid certification, unless certification of the bed by the division does not increase the total number in the state of Medicaid-certified beds in intermediate care facilities for individuals with an intellectual disability.

Section 76. Section **26B-3-311**, which is renumbered from Section 26-18-503 is renumbered and amended to read:

[~~26-18-503~~]. 26B-3-311. Authorization to renew, transfer, or increase Medicaid certified programs -- Reimbursement methodology.

(1) (a) The division may renew Medicaid certification of a certified program if the program, without lapse in service to Medicaid recipients, has its nursing care facility program certified by the division at the same physical facility as long as the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) The division may renew Medicaid certification of a nursing care facility program that is not currently certified if:

(i) since the day on which the program last operated with Medicaid certification:

(A) the physical facility where the program operated has functioned solely and continuously as a nursing care facility; and

(B) the owner of the program has not, under this section or Section 26-18-505, transferred to another nursing care facility program the license for any of the Medicaid beds in the program; and

(ii) except as provided in Subsection 26-18-502(4), the number of beds granted renewed Medicaid certification does not exceed the number of beds certified at the time the program last operated with Medicaid certification, excluding a period of time where the program operated with temporary certification under Subsection 26-18-504(3).

(2) (a) The division may issue a Medicaid certification for a new nursing care facility program if a current owner of the Medicaid certified program transfers its ownership of the Medicaid certification to the new nursing care facility program and the new nursing care facility program meets all of the following conditions:

(i) the new nursing care facility program operates at the same physical facility as the previous Medicaid certified program;

(ii) the new nursing care facility program gives a written assurance to the director in accordance with Subsection (4);

(iii) the new nursing care facility program receives the Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient; and

(iv) the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) A nursing care facility program that receives Medicaid certification under the provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing care facility program if the new nursing care facility program:

(i) is not owned in whole or in part by the previous nursing care facility program; or

(ii) is not a successor in interest of the previous nursing care facility program.

(3) The division may issue a Medicaid certification to a nursing care facility program that was previously a certified program but now resides in a new or renovated physical facility if the nursing care facility program meets all of the following:

(a) the nursing care facility program met all applicable requirements for Medicaid certification at the time of closure;

(b) the new or renovated physical facility is in the same county or within a five-mile radius of the original physical facility;

(c) the time between which the certified program ceased to operate in the original facility and will begin to operate in the new physical facility is not more than three years, unless:

(i) an emergency is declared by the president of the United States or the governor, affecting the building or renovation of the physical facility;

(ii) the director approves an exception to the three-year requirement for any nursing care facility program within the three-year requirement;

(iii) the provider submits documentation supporting a request for an extension to the director that demonstrates a need for an extension; and

(iv) the exception does not extend for more than two years beyond the three-year

requirement;

(d) if Subsection (3)(c) applies, the certified program notifies the department within 90 days after ceasing operations in its original facility, of its intent to retain its Medicaid certification;

(e) the provider gives written assurance to the director in accordance with Subsection (4) that no third party has a legitimate claim to operate a certified program at the previous physical facility; and

(f) the bed capacity in the physical facility has not been expanded unless the director has approved additional beds in accordance with Subsection (5).

(4) (a) The entity requesting Medicaid certification under Subsections (2) and (3) shall give written assurances satisfactory to the director or the director's designee that:

(i) no third party has a legitimate claim to operate the certified program;

(ii) the requesting entity agrees to defend and indemnify the department against any claims by a third party who may assert a right to operate the certified program; and

(iii) if a third party is found, by final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

(b) If a finding is made under the provisions of Subsection (4)(a)(iii):

(i) the certified program shall immediately surrender its Medicaid certification and comply with division rules regarding billing for Medicaid and the provision of services to Medicaid patients; and

(ii) the department shall transfer the surrendered Medicaid certification to the third party who prevailed under Subsection (4)(a)(iii).

(5) (a) The director may approve additional nursing care facility programs for Medicaid certification, or additional beds for Medicaid certification within an existing nursing care facility program, if a nursing care facility or other interested party requests Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program, and the nursing care facility program or other interested party complies with this section.

(b) The nursing care facility or other interested party requesting Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility

program under Subsection (5)(a) shall submit to the director:

(i) proof of the following as reasonable evidence that bed capacity provided by Medicaid certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient:

(A) nursing care facility occupancy levels for all existing and proposed facilities will be at least 90% for the next three years;

(B) current nursing care facility occupancy is 90% or more; or

(C) there is no other nursing care facility within a 35-mile radius of the nursing care facility requesting the additional certification; and

(ii) an independent analysis demonstrating that at projected occupancy rates the nursing care facility's after-tax net income is sufficient for the facility to be financially viable.

(c) Any request for additional beds as part of a renovation project are limited to the maximum number of beds allowed in Subsection (7).

(d) The director shall determine whether to issue additional Medicaid certification by considering:

(i) whether bed capacity provided by certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient, based on the information submitted to the director under Subsection (5)(b);

(ii) whether the county or group of counties impacted by the requested additional Medicaid certification is underserved by specialized or unique services that would be provided by the nursing care facility;

(iii) whether any Medicaid certified beds are subject to a claim by a previous certified program that may reopen under the provisions of Subsections (2) and (3);

(iv) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of Medicaid recipients; and

(v) (A) whether the existing certified programs within the county or group of counties have provided services of sufficient quality to merit at least a two-star rating in the Medicare Five-Star Quality Rating System over the previous three-year period; and

(B) information obtained under Subsection (9).

(6) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility

property reimbursement methodology to:

(a) only pay that portion of the property component of rates, representing actual bed usage by Medicaid clients as a percentage of the greater of:

(i) actual occupancy; or

(ii) (A) for a nursing care facility other than a facility described in Subsection (6)(a)(ii)(B), 85% of total bed capacity; or

(B) for a rural nursing care facility, 65% of total bed capacity; and

(b) not allow for increases in reimbursement for property values without major renovation or replacement projects as defined by the department by rule.

(7) (a) Except as provided in Subsection 26-18-502(3), if a nursing care facility does not seek Medicaid certification for a bed under Subsections (1) through (6), the department shall, notwithstanding Subsections 26-18-504(3)(a) and (b), grant Medicaid certification for additional beds in an existing Medicaid certified nursing care facility that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility if:

(i) the nursing care facility program was previously a certified program for all beds but now resides in a new facility or in a facility that underwent major renovations involving major structural changes, with 50% or greater facility square footage design changes, requiring review and approval by the department;

(ii) the nursing care facility meets the quality of care regulations issued by CMS; and

(iii) the total number of additional beds in the facility granted Medicaid certification under this section does not exceed 10% of the number of licensed beds in the facility.

(b) The department may not revoke the Medicaid certification of a bed under this Subsection (7) as long as the provisions of Subsection (7)(a)(ii) are met.

(8) (a) If a nursing care facility or other interested party indicates in its request for additional Medicaid certification under Subsection (5)(a) that the facility will offer specialized or unique services, but the facility does not offer those services after receiving additional Medicaid certification, the director shall revoke the additional Medicaid certification.

(b) The nursing care facility program shall obtain Medicaid certification for any additional Medicaid beds approved under Subsection (5) or (7) within three years of the date of the director's approval, or the approval is void.

(9) (a) If the director makes an initial determination that quality standards under

Subsection (5)(d)(v) have not been met in a rural county or group of rural counties over the previous three-year period, the director shall, before approving certification of additional Medicaid beds in the rural county or group of counties:

(i) notify the certified program that has not met the quality standards in Subsection (5)(d)(v) that the director intends to certify additional Medicaid beds under the provisions of Subsection (5)(d)(v); and

(ii) consider additional information submitted to the director by the certified program in a rural county that has not met the quality standards under Subsection (5)(d)(v).

(b) The notice under Subsection (9)(a) does not give the certified program that has not met the quality standards under Subsection (5)(d)(v), the right to legally challenge or appeal the director's decision to certify additional Medicaid beds under Subsection (5)(d)(v).

Section 77. Section **26B-3-312**, which is renumbered from Section 26-18-504 is renumbered and amended to read:

[~~26-18-504~~]. 26B-3-312. Appeals of division decision -- Rulemaking authority -- Application of act.

(1) A decision by the director under this part to deny Medicaid certification for a nursing care facility program or to deny additional bed capacity for an existing certified program is subject to review under the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act.

(2) The department shall make rules to administer and enforce [~~this part~~] Sections 26B-3-310 through 26B-3-313 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) (a) In the event the department is at risk for a federal disallowance with regard to a Medicaid recipient being served in a nursing care facility program that is not Medicaid certified, the department may grant temporary Medicaid certification to that facility for up to 24 months.

(b) (i) The department may extend a temporary Medicaid certification granted to a facility under Subsection (3)(a):

(A) for the number of beds in the nursing care facility occupied by a Medicaid recipient; and

(B) for the period of time during which the Medicaid recipient resides at the facility.

(ii) A temporary Medicaid certification granted under this Subsection (3) is revoked upon:

(A) the discharge of the patient from the facility; or

(B) the patient no longer residing at the facility for any reason.

(c) The department may place conditions on the temporary certification granted under Subsections (3)(a) and (b), such as:

(i) not allowing additional admissions of Medicaid recipients to the program; and

(ii) not paying for the care of the patient after October 1, 2008, with state only dollars.

Section 78. Section **26B-3-313**, which is renumbered from Section 26-18-505 is renumbered and amended to read:

[~~26-18-505~~]. 26B-3-313. Authorization to sell or transfer licensed Medicaid beds -- Duties of transferor -- Duties of transferee -- Duties of division.

(1) This section provides a method to transfer or sell the license for a Medicaid bed from a nursing care facility program to another entity that is in addition to the authorization to transfer under Section [~~26-18-503~~] 26B-3-311.

(2) (a) A nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds in accordance with Subsection (2)(b) if:

(i) at the time of the transfer, and with respect to the license for the Medicaid bed that will be transferred, the nursing care facility program that will transfer the Medicaid license meets all applicable regulations for Medicaid certification;

(ii) the nursing care facility program gives a written assurance, which is postmarked or has proof of delivery 30 days before the transfer, to the director and to the transferee in accordance with Subsection [~~26-18-503~~] 26B-3-311(4);

(iii) the nursing care facility program that will transfer the license for a Medicaid bed notifies the division in writing, which is postmarked or has proof of delivery 30 days before the transfer, of:

(A) the number of bed licenses that will be transferred;

(B) the date of the transfer; and

(C) the identity and location of the entity receiving the transferred licenses; and

(iv) if the nursing care facility program for which the license will be transferred or purchased is located in an urban county with a nursing care facility average annual occupancy

rate over the previous two years less than or equal to 75%, the nursing care facility program transferring or selling the license demonstrates to the satisfaction of the director that the sale or transfer:

(A) will not result in an excessive number of Medicaid certified beds within the county or group of counties that would be impacted by the transfer or sale; and

(B) best meets the needs of Medicaid recipients.

(b) Except as provided in Subsection (2)(c), a nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds to:

(i) a nursing care facility program that has the same owner or successor in interest of the same owner;

(ii) a nursing care facility program that has a different owner; or

(iii) a related-party nonnursing-care-facility entity that wants to hold one or more of the licenses for a nursing care facility program not yet identified, as long as:

(A) the licenses are subsequently transferred or sold to a nursing care facility program within three years; and

(B) the nursing care facility program notifies the director of the transfer or sale in accordance with Subsection (2)(a)(iii).

(c) A nursing care facility program may not transfer or sell one or more of its licenses for Medicaid beds to an entity under Subsection (2)(b)(i), (ii), or (iii) that is located in a rural county unless the entity requests, and the director issues, Medicaid certification for the beds under Subsection 26-18-503(5).

(3) A nursing care facility program or entity under Subsection (2)(b)(i), (ii), or (iii) that receives or purchases a license for a Medicaid bed under Subsection (2)(b):

(a) may receive a license for a Medicaid bed from more than one nursing care facility program;

(b) shall give the division notice, which is postmarked or has proof of delivery within 14 days of the nursing care facility program or entity seeking Medicaid certification of beds in the nursing care facility program or entity, of the total number of licenses for Medicaid beds that the entity received and who it received the licenses from;

(c) may only seek Medicaid certification for the number of licensed beds in the nursing care facility program equal to the total number of licenses for Medicaid beds received by the

entity;

(d) does not have to demonstrate need or seek approval for the Medicaid licensed bed under Subsection [~~26-18-503~~] 26B-3-311(5), except as provided in Subsections (2)(a)(iv) and (2)(c);

(e) shall meet the standards for Medicaid certification other than those in Subsection [~~26-18-503~~] 26B-3-311(5), including personnel, services, contracts, and licensing of facilities under [~~Chapter 21, Health Care Facility Licensing and Inspection Act~~] Chapter 2, Part 2, Health Care Facility Licensing and Inspection; and

(f) shall obtain Medicaid certification for the licensed Medicaid beds within three years of the date of transfer as documented under Subsection (2)(a)(iii)(B).

(4) (a) When the division receives notice of a transfer of a license for a Medicaid bed under Subsection (2)(a)(iii)(A), the department shall reduce the number of licenses for Medicaid beds at the transferring nursing care facility:

(i) equal to the number of licenses transferred; and

(ii) effective on the date of the transfer as reported under Subsection (2)(a)(iii)(B).

(b) For purposes of Section [~~26-18-502~~] 26B-3-310, the division shall approve Medicaid certification for the receiving nursing care facility program or entity:

(i) in accordance with the formula established in Subsection (3)(c); and

(ii) if:

(A) the nursing care facility seeks Medicaid certification for the transferred licenses within the time limit required by Subsection (3)(f); and

(B) the nursing care facility program meets other requirements for Medicaid certification under Subsection (3)(e).

(c) A license for a Medicaid bed may not be approved for Medicaid certification without meeting the requirements of Sections [~~26-18-502 and 26-18-503~~] 26B-3-310 and 26B-3-311 if:

(i) the license for a Medicaid bed is transferred under this section but the receiving entity does not obtain Medicaid certification for the licensed bed within the time required by Subsection (3)(f); or

(ii) the license for a Medicaid bed is transferred under this section but the license is no longer eligible for Medicaid certification.

Section 79. Section **26B-3-401**, which is renumbered from Section 26-35a-103 is renumbered and amended to read:

Part 4. Nursing Care Facility Assessment

[~~26-35a-103~~]. 26B-3-401. Definitions.

As used in this [~~chapter~~] part:

(1) (a) "Nursing care facility" means:

(i) a nursing care facility [~~described in Subsection 26-21-2(17)~~] as defined in Section 26B-2-201;

(ii) beginning January 1, 2006, a designated swing bed in:

(A) a general acute hospital as defined in [~~Subsection 26-21-2(11)~~] Section 26B-2-201; and

(B) a critical access hospital which meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2) (1998); and

(iii) an intermediate care facility for people with an intellectual disability that is licensed under Section [~~26-21-13.5~~] 26B-2-2XX.

(b) "Nursing care facility" does not include:

(i) the Utah State Developmental Center;

(ii) the Utah State Hospital;

(iii) a general acute hospital, specialty hospital, or small health care facility as those terms are defined in Section [~~26-21-2~~] 26B-2-201; or

(iv) a Utah State Veterans Home.

(2) "Patient day" means each calendar day in which an individual patient is admitted to the nursing care facility during a calendar month, even if on a temporary leave of absence from the facility.

Section 80. Section **26B-3-402**, which is renumbered from Section 26-35a-102 is renumbered and amended to read:

[~~26-35a-102~~]. 26B-3-402. Legislative findings.

(1) The Legislature finds that there is an important state purpose to improve the quality of care given to persons who are elderly and to people who have a disability, in long-term care nursing facilities.

(2) The Legislature finds that in order to improve the quality of care to those persons

described in Subsection (1), the rates paid to the nursing care facilities by the Medicaid program must be adequate to encourage and support quality care.

(3) The Legislature finds that in order to meet the objectives in Subsections (1) and (2), adequate funding must be provided to increase the rates paid to nursing care facilities providing services pursuant to the Medicaid program.

Section 81. Section **26B-3-403**, which is renumbered from Section 26-35a-104 is renumbered and amended to read:

[~~26-35a-104~~]. 26B-3-403. Collection, remittance, and payment of nursing care facilities assessment.

(1) (a) Beginning July 1, 2004, an assessment is imposed upon each nursing care facility in the amount designated in Subsection (1)(c).

(b) (i) The department shall establish by rule, a uniform rate per non-Medicare patient day that may not exceed 6% of the total gross revenue for services provided to patients of all nursing care facilities licensed in this state.

(ii) For purposes of Subsection (1)(b)(i), total revenue does not include charitable contribution received by a nursing care facility.

(c) The department shall calculate the assessment imposed under Subsection (1)(a) by multiplying the total number of patient days of care provided to non-Medicare patients by the nursing care facility, as provided to the department pursuant to Subsection (3)(a), by the uniform rate established by the department pursuant to Subsection (1)(b).

(2) (a) The assessment imposed by this [~~chapter~~] part is due and payable on a monthly basis on or before the last day of the month next succeeding each monthly period.

(b) The collecting agent for this assessment shall be the department which is vested with the administration and enforcement of this [~~chapter~~] part, including the right to audit records of a nursing care facility related to patient days of care for the facility.

(c) The department shall forward proceeds from the assessment imposed by this [~~chapter~~] part to the state treasurer for deposit in the expendable special revenue fund as specified in Section 26-35a-106.

(3) Each nursing care facility shall, on or before the end of the month next succeeding each calendar monthly period, file with the department:

(a) a report which includes:

(i) the total number of patient days of care the facility provided to non-Medicare patients during the preceding month;

(ii) the total gross revenue the facility earned as compensation for services provided to patients during the preceding month; and

(iii) any other information required by the department; and

(b) a return for the monthly period, and shall remit with the return the assessment required by this [~~chapter~~] part to be paid for the period covered by the return.

(4) Each return shall contain information and be in the form the department prescribes by rule.

(5) The assessment as computed in the return is an allowable cost for Medicaid reimbursement purposes.

(6) The department may by rule, extend the time for making returns and paying the assessment.

(7) Each nursing care facility that fails to pay any assessment required to be paid to the state, within the time required by this [~~chapter~~] part, or that fails to file a return as required by this [~~chapter~~] part, shall pay, in addition to the assessment, penalties and interest as provided in Section 26-35a-105.

Section 82. Section **26B-3-404**, which is renumbered from Section 26-35a-105 is renumbered and amended to read:

[~~26-35a-105~~]. 26B-3-404. Penalties and interest.

(1) The penalty for failure to file a return or pay the assessment due within the time prescribed by this [~~chapter~~] part is the greater of $50, or 1% of the assessment due on the return.

(2) For failure to pay within 30 days of a notice of deficiency of assessment required to be paid, the penalty is the greater of $50 or 5% of the assessment due.

(3) The penalty for underpayment of the assessment is as follows:

(a) If any underpayment of assessment is due to negligence, the penalty is 25% of the underpayment.

(b) If the underpayment of the assessment is due to intentional disregard of law or rule, the penalty is 50% of the underpayment.

(4) For intent to evade the assessment, the penalty is 100% of the underpayment.

(5) The rate of interest applicable to an underpayment of an assessment under this [~~chapter~~] part or an unpaid penalty under this [~~chapter~~] part is 12% annually.

(6) The department may waive the imposition of a penalty for good cause.

Section 83. Section **26B-3-405**, which is renumbered from Section 26-35a-106 is renumbered and amended to read:

[~~26-35a-106~~]. 26B-3-405. Nursing Care Facilities Provider Assessment Expendable Revenue Fund -- Creation -- Deposits -- Uses.

(1) There is created an expendable special revenue fund known as the "Nursing Care Facilities Provider Assessment Fund" consisting of:

(a) the assessments collected by the department under this chapter;

(b) fines paid by nursing care facilities for excessive Medicare inpatient revenue under Section 26-21-23;

(c) money appropriated or otherwise made available by the Legislature;

(d) any interest earned on the fund; and

(e) penalties levied with the administration of this chapter.

(2) Money in the fund shall only be used by the Medicaid program:

(a) to the extent authorized by federal law, to obtain federal financial participation in the Medicaid program;

(b) to provide the increased level of hospice reimbursement resulting from the nursing care facilities assessment imposed under Section 26-35a-104;

(c) for the Medicaid program to make quality incentive payments to nursing care facilities, subject to approval of a Medicaid state plan amendment to do so by the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services;

(d) to increase the rates paid before July 1, 2004, to nursing care facilities for providing services pursuant to the Medicaid program; and

(e) for administrative expenses, if the administrative expenses for the fiscal year do not exceed 3% of the money deposited into the fund during the fiscal year.

(3) The department may not spend the money in the fund to replace existing state expenditures paid to nursing care facilities for providing services under the Medicaid program, except for increased costs due to hospice reimbursement under Subsection (2)(b).

Section 84. Section **26B-3-406**, which is renumbered from Section 26-35a-107 is renumbered and amended to read:

[~~26-35a-107~~]. 26B-3-406. Adjustment to nursing care facility Medicaid reimbursement rates.

If federal law or regulation prohibits the money in the Nursing Care Facilities Provider Assessment Fund from being used in the manner set forth in Subsection 26-35a-106(1)(b), the rates paid to nursing care facilities for providing services pursuant to the Medicaid program shall be changed:

(1) except as otherwise provided in Subsection (2), to the rates paid to nursing care facilities on June 30, 2004; or

(2) if the Legislature or the department has on or after July 1, 2004, changed the rates paid to facilities through a manner other than the use of expenditures from the Nursing Care Facilities Provider Assessment Fund, to the rates provided for by the Legislature or the department.

Section 85. Section **26B-3-407**, which is renumbered from Section 26-35a-108 is renumbered and amended to read:

[~~26-35a-108~~]. 26B-3-407. Intermediate care facility for people with an intellectual disability -- Uniform rate.

An intermediate care facility for people with an intellectual disability is subject to all the provisions of this [~~chapter~~] part, except that the department shall establish a uniform rate for an intermediate care facility for people with an intellectual disability that:

(1) is based on the same formula specified for nursing care facilities under the provisions of Subsection 26-35a-104(1)(b); and

(2) may be different than the uniform rate established for other nursing care facilities.

Section 86. Section **26B-3-501**, which is renumbered from Section 26-36b-103 is renumbered and amended to read:

Part 5. Inpatient Hospital Assessment

[~~26-36b-103~~]. 26B-3-501. Definitions.

As used in this [~~chapter~~] part:

(1) "Assessment" means the inpatient hospital assessment established by this [~~chapter~~] 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 Health Care Financing within the department.

(5) "Enhancement waiver program" means the program established by the Primary Care Network enhancement waiver program described in Section 26-18-416.

(6) "Health coverage improvement program" means the health coverage improvement program described in Section 26-18-411.

(7) "Hospital share" means the hospital share described in Section 26-36b-203.

(8) "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 26-18-405.

(9) "Medicaid waiver expansion" means a Medicaid expansion in accordance with Section 26-18-3.9 or 26-18-415.

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

(11) (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.

(12) (a) "Private hospital" means:

(i) a general acute hospital, as defined in Section 26-21-2, that is privately owned and operating in the state; and

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

(A) rehabilitation;

(B) psychiatric care;

(C) chemical dependency services; or

(D) long-term acute care services.

(b) "Private hospital" does not include a facility for residential treatment as defined in Section 62A-2-101.

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

(14) "Upper payment limit gap" means the difference between the private hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments, as determined in accordance with 42 C.F.R. Sec. 447.321.

Section 87. Section **26B-3-502**, which is renumbered from Section 26-36b-102 is renumbered and amended to read:

[~~26-36b-102~~]. 26B-3-502. Application.

(1) Other than for the imposition of the assessment described in this [~~chapter~~] part, nothing in this [~~chapter~~] part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under any:

(a) state law;

(b) ad valorem property taxes;

(c) sales or use taxes; or

(d) other taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.

(2) All assessments paid under this [~~chapter~~] part may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This [~~chapter~~] part does not authorize a political subdivision of the state to:

(a) license a hospital for revenue;

(b) impose a tax or assessment upon a hospital; or

(c) impose a tax or assessment measured by the income or earnings of a hospital.

Section 88. Section **26B-3-503**, which is renumbered from Section 26-36b-201 is renumbered and amended to read:

[~~26-36b-201~~]. 26B-3-503. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of CMS approval of:

(i) the health coverage improvement program waiver under Section 26-18-411; and

(ii) the assessment under this [~~chapter~~] part;

(b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and

(c) in accordance with Section 26-36b-202.

(2) Subject to Section 26-36b-203, the assessment imposed by this [~~chapter~~] part is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26-36b-210 have been paid.

(3) The first quarterly payment is not due until at least three months after the earlier of the effective dates of the coverage provided through:

(a) the health coverage improvement program;

(b) the enhancement waiver program; or

(c) the Medicaid waiver expansion.

Section 89. Section **26B-3-504**, which is renumbered from Section 26-36b-202 is renumbered and amended to read:

[~~26-36b-202~~]. 26B-3-504. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The collecting agent for the assessment imposed under Section 26-36b-201 is the department.

(2) The department is vested with the administration and enforcement of this [~~chapter~~] part, and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this [~~chapter~~] part;

(b) audit records of a facility that:

(i) is subject to the assessment imposed by this [~~chapter~~] part; and

(ii) does not file a Medicare cost report; and

(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.

(3) The department shall:

(a) administer the assessment in this [~~chapter~~] part separately from the assessment in Chapter 36d, Hospital Provider Assessment Act; and

(b) deposit assessments collected under this [~~chapter~~] part into the Medicaid Expansion Fund created by Section 26-36b-208.

Section 90. Section **26B-3-505**, which is renumbered from Section 26-36b-203 is renumbered and amended to read:

[~~26-36b-203~~]. 26B-3-505. Quarterly notice.

(1) Quarterly assessments imposed by this [~~chapter~~] part shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

(2) The department may, by rule, extend the time for paying the assessment.

Section 91. Section **26B-3-506**, which is renumbered from Section 26-36b-204 is renumbered and amended to read:

[~~26-36b-204~~]. 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 26-18-411;

(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 [~~chapter~~] 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 26-18-3.9(8), 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 92. Section **26B-3-507**, which is renumbered from Section 26-36b-205 is renumbered and amended to read:

[~~26-36b-205~~]. 26B-3-507. Calculation of assessment.

(1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a quarterly basis for each private hospital in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, described in Subsections 26-36b-204(1) and 26-36b-204(3), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this [~~chapter~~] part.

(e) Any quarterly changes to the uniform assessment rate shall be applied uniformly to all assessed private hospitals.

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

(a) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2013, and June 30, 2014; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

(3) (a) If a hospital's fiscal year Medicare cost report is not contained in the CMS Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare cost report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i); and

(iii) failure to submit discharge information shall result in an audit of the hospital's records and a penalty equal to 5% of the calculated assessment.

(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the assessment for each hospital shall be separately calculated by the department; and

(b) each separate hospital shall pay the assessment imposed by this [~~chapter~~] part.

(5) If multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

Section 93. Section **26B-3-508**, which is renumbered from Section 26-36b-206 is renumbered and amended to read:

[~~26-36b-206~~]. 26B-3-508. State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) The state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund created in Section 26-36b-208, in accordance with this section.

(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of CMS approval of:

(a) the health improvement program waiver under Section 26-18-411; or

(b) the assessment for private hospitals in this [~~chapter~~] part.

(3) The intergovernmental transfer is apportioned as follows:

(a) the state teaching hospital is responsible for:

(i) 30% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a) through (c); and

(ii) 0% of the hospital share specified in Subsection 26-36b-204(1)(d); and

(b) non-state government hospitals are responsible for:

(i) 1% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a) through (c); and

(ii) 0% of the hospital share specified in Subsection 26-36b-204(1)(d).

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the amounts designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

Section 94. Section **26B-3-509**, which is renumbered from Section 26-36b-207 is renumbered and amended to read:

[~~26-36b-207~~]. 26B-3-509. Penalties and interest.

(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this [~~chapter~~] part, within the time required by this [~~chapter~~] part, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.

(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:

(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

(i) any unpaid quarterly assessment or intergovernmental transfer; and

(ii) any unpaid penalty assessment.

(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this [~~chapter~~] part.

Section 95. Section **26B-3-510**, which is renumbered from Section 26-36b-209 is renumbered and amended to read:

[~~26-36b-209~~]. 26B-3-510. Hospital reimbursement.

(1) If the health coverage improvement program, the enhancement waiver program, or

the Medicaid waiver expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include, in a contract to provide benefits under the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion, a requirement that the Medicaid accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

(2) If the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

Section 96. Section **26B-3-511**, which is renumbered from Section 26-36b-210 is renumbered and amended to read:

[~~26-36b-210~~]. 26B-3-511. Outpatient upper payment limit supplemental payments.

(1) Beginning on the effective date of the assessment imposed under this [~~chapter~~] part, and for each subsequent fiscal year, the department shall implement an outpatient upper payment limit program for private hospitals that shall supplement the reimbursement to private hospitals in accordance with Subsection (2).

(2) The division shall ensure that supplemental payment to Utah private hospitals under Subsection (1):

(a) does not exceed the positive upper payment limit gap; and

(b) is allocated based on the Medicaid state plan.

(3) The department shall use the same outpatient data to allocate the payments under Subsection (2) and to calculate the upper payment limit gap.

(4) The supplemental payments to private hospitals under Subsection (1) are payable for outpatient hospital services provided on or after the later of:

(a) July 1, 2016;

(b) the effective date of the Medicaid state plan amendment necessary to implement the payments under this section; or

(c) the effective date of the coverage provided through the health coverage

improvement program waiver.

Section 97. Section **26B-3-512**, which is renumbered from Section 26-36b-211 is renumbered and amended to read:

[~~26-36b-211~~]. 26B-3-512. Repeal of assessment.

(1) The assessment imposed by this [~~chapter~~] part shall be repealed when:

(a) the executive director certifies that:

(i) action by Congress is in effect that disqualifies the assessment imposed by this [~~chapter~~] part from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(ii) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(A) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(B) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this [~~chapter~~] part; or

(iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015; or

(b) this [~~chapter~~] part is repealed in accordance with Section 63I-1-226.

(2) If the assessment is repealed under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this [~~chapter~~] part;

(b) the department shall disburse money in the special Medicaid Expansion Fund in accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

(c) any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this [~~chapter~~] part shall be refunded to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years; and

(d) any money remaining in the Medicaid Expansion Fund after the disbursements described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of

the fiscal year that the assessment is suspended.

Section 98. Section **26B-3-601**, which is renumbered from Section 26-36c-102 is renumbered and amended to read:

Part 6. Medicaid Expansion Hospital Assessment

[~~26-36c-102~~]. 26B-3-601. Definitions.

As used in this [~~chapter~~] part:

(1) "Assessment" means the Medicaid expansion hospital assessment established by this [~~chapter~~] 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 Health Care Financing within the department.

(5) "Hospital share" means the hospital share described in Section 26-36c-203.

(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 26-18-405.

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

(8) "Medicaid waiver expansion" means the same as that term is defined in Section 26-18-415.

(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 26-21-2; 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 62A-2-101.

(12) "Qualified Medicaid expansion" means an expansion of the Medicaid program in accordance with Subsection 26-18-3.9(5).

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

Section 99. Section **26B-3-602**, which is renumbered from Section 26-36c-103 is renumbered and amended to read:

[~~26-36c-103~~]. 26B-3-602. Application.

(1) Other than for the imposition of the assessment described in this [~~chapter~~] part, nothing in this [~~chapter~~] part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under any:

(a) state law;

(b) ad valorem property tax requirement;

(c) sales or use tax requirement; or

(d) other requirements imposed by taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.

(2) A hospital paying an assessment under this [~~chapter~~] part may include the assessment as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This [~~chapter~~] part does not authorize a political subdivision of the state to:

(a) license a hospital for revenue;

(b) impose a tax or assessment upon a hospital; or

(c) impose a tax or assessment measured by the income or earnings of a hospital.

Section 100. Section **26B-3-603**, which is renumbered from Section 26-36c-201 is renumbered and amended to read:

[~~26-36c-201~~]. 26B-3-603. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of:

(i) April 1, 2019; and

(ii) CMS approval of the assessment under this [~~chapter~~] part;

(b) in the amount designated in Sections 26-36c-204 and 26-36c-205; and

(c) in accordance with Section 26-36c-202.

(2) The assessment imposed by this [~~chapter~~] part is due and payable in accordance with Subsection 26-36c-202(4).

Section 101. Section **26B-3-604**, which is renumbered from Section 26-36c-202 is renumbered and amended to read:

[~~26-36c-202~~]. 26B-3-604. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The department shall act as the collecting agent for the assessment imposed under Section 26-36c-201.

(2) The department shall administer and enforce the provisions of this [~~chapter~~] part, and may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this [~~chapter~~] part;

(b) audit records of a facility that:

(i) is subject to the assessment imposed under this [~~chapter~~] part; and

(ii) does not file a Medicare cost report; and

(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.

(3) The department shall:

(a) administer the assessment in this part separately from the assessments in Chapter 36d, Hospital Provider Assessment Act, and Chapter 36b, Inpatient Hospital Assessment Act; and

(b) deposit assessments collected under this [~~chapter~~] part into the Medicaid Expansion Fund.

(4) (a) Hospitals shall pay the quarterly assessments imposed by this [~~chapter~~] part to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

(b) The department may make rules creating requirements to allow the time for paying the assessment to be extended.

Section 102. Section **26B-3-605**, which is renumbered from Section 26-36c-203 is renumbered and amended to read:

[~~26-36c-203~~]. 26B-3-605. Hospital share.

(1) The hospital share is:

(a) for the period from April 1, 2019, through June 30, 2020, $15,000,000; and

(b) beginning July 1, 2020, 100% of the state's net cost of the qualified Medicaid expansion, after deducting appropriate offsets and savings expected as a result of implementing the qualified Medicaid expansion, including:

(i) savings from:

(A) the Primary Care Network program;

(B) the health coverage improvement program, as defined in Section 26-18-411;

(C) the state portion of inpatient prison medical coverage;

(D) behavioral health coverage; and

(E) county contributions to the non-federal share of Medicaid expenditures; and

(ii) any funds appropriated to the Medicaid Expansion Fund.

(2) (a) Beginning July 1, 2020, the hospital share is capped at no more than $15,000,000 annually.

(b) Beginning July 1, 2020, the division shall prorate the cap specified in Subsection (2)(a) in any year in which the qualified Medicaid expansion is not in effect for the full fiscal year.

Section 103. Section **26B-3-606**, which is renumbered from Section 26-36c-204 is

renumbered and amended to read:

[~~26-36c-204~~]. 26B-3-606. Hospital financing.

(1) Private hospitals shall be assessed under this [~~chapter~~] part for the portion of the hospital share described in Section 26-36c-209.

(2) In the report described in Subsection 26-18-3.9(8), 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 104. Section **26B-3-607**, which is renumbered from Section 26-36c-205 is renumbered and amended to read:

[~~26-36c-205~~]. 26B-3-607. Calculation of assessment.

(1) (a) Except as provided in Subsection (1)(b), each private hospital shall pay an annual assessment due on the last day of each quarter in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and more than 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection 26-36c-204(1), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this [~~chapter~~] part.

(e) The division shall apply any quarterly changes to the uniform assessment rate uniformly to all assessed private hospitals.

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall

determine a hospital's discharges as follows:

(a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

(3) (a) If a hospital's fiscal year Medicare cost report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare cost report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i); and

(iii) if the hospital fails to submit discharge information, the division shall audit the hospital's records and may impose a penalty equal to 5% of the calculated assessment.

(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the division shall calculate the assessment for each hospital separately; and

(b) each separate hospital shall pay the assessment imposed by this [~~chapter~~] part.

(5) If multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

Section 105. Section **26B-3-608**, which is renumbered from Section 26-36c-206 is renumbered and amended to read:

[~~26-36c-206~~]. 26B-3-608. State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) A state teaching hospital and a non-state government hospital shall make an

intergovernmental transfer to the Medicaid Expansion Fund, in accordance with this section.

(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of:

(a) April 1, 2019; or

(b) CMS approval of the assessment for private hospitals in this [~~chapter~~] part.

(3) The intergovernmental transfer is apportioned between the non-state government hospitals as follows:

(a) the state teaching hospital shall pay for the portion of the hospital share described in Section 26-36c-209; and

(b) non-state government hospitals shall pay for the portion of the hospital share described in Section 26-36c-209.

(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:

(a) the method of calculating the amounts designated in Subsection (3); and

(b) the schedule for the intergovernmental transfers.

Section 106. Section **26B-3-609**, which is renumbered from Section 26-36c-207 is renumbered and amended to read:

[~~26-36c-207~~]. 26B-3-609. Penalties.

(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this [~~chapter~~] part, within the time required by this [~~chapter~~] part, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.

(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:

(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

(i) any unpaid quarterly assessment or intergovernmental transfer; and

(ii) any unpaid penalty assessment.

(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive or reduce any of the penalties imposed under this [~~chapter~~] part.

Section 107. Section **26B-3-610**, which is renumbered from Section 26-36c-208 is renumbered and amended to read:

[~~26-36c-208~~]. 26B-3-610. Hospital reimbursement.

(1) If the qualified Medicaid expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include in a contract to provide benefits under the qualified Medicaid expansion a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

(2) If the qualified Medicaid expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits the department or a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

Section 108. Section **26B-3-611**, which is renumbered from Section 26-36c-209 is renumbered and amended to read:

[~~26-36c-209~~]. 26B-3-611. Hospital financing of the hospital share.

(1) For the first two full fiscal years that the assessment is in effect, the department shall:

(a) assess private hospitals under this [~~chapter~~] part for 69% of the hospital share;

(b) require the state teaching hospital to make an intergovernmental transfer under this [~~chapter~~] part for 30% of the hospital share; and

(c) require non-state government hospitals to make an intergovernmental transfer under this [~~chapter~~] part for 1% of the hospital share.

(2) (a) At the beginning of the third full fiscal year that the assessment is in effect, and at the beginning of each subsequent fiscal year, the department may set a different percentage share for private hospitals, the state teaching hospital, and non-state government hospitals by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, with input from private hospitals and private teaching hospitals.

(b) If the department does not set a different percentage share under Subsection (2)(a),

the percentage shares in Subsection (1) shall apply.

Section 109. Section **26B-3-612**, which is renumbered from Section 26-36c-210 is renumbered and amended to read:

[~~26-36c-210~~]. 26B-3-612. Suspension of assessment.

(1) The department shall suspend the assessment imposed by this [~~chapter~~] part when the executive director certifies that:

(a) action by Congress is in effect that disqualifies the assessment imposed by this [~~chapter~~] part from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(b) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(i) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this [~~chapter~~] part; or

(c) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015.

(2) If the assessment is suspended under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this [~~chapter~~] part;

(b) the division shall disburse money in the Medicaid Expansion Fund that was derived from assessments imposed by this [~~chapter~~] part in accordance with the requirements in Subsection 26-36b-208(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment; and

(c) the division shall refund any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this [~~chapter~~] part to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years.

Section 110. Section **26B-3-701**, which is renumbered from Section 26-36d-103 is renumbered and amended to read:

Part 7. Hospital Provider Assessment

[~~26-36d-103~~]. 26B-3-701. Definitions.

As used in this [~~chapter~~] part:

(1) "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 26-18-405.

(2) "Assessment" means the Medicaid hospital provider assessment established by this [~~chapter~~] part.

(3) "Discharges" means the number of total hospital discharges reported on Worksheet S-3 Part I, column 15, lines 12, 14, and 14.01 of the 2552-96 Medicare Cost Report or on Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare Cost Report for the applicable assessment year.

(4) "Division" means the Division of Health Care Financing of the department.

(5) "Hospital":

(a) means a privately owned:

(i) general acute hospital operating in the state as defined in Section 26-21-2; and

(ii) specialty hospital operating in the state, which shall include a privately owned hospital whose inpatient admissions are predominantly:

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services; and

(b) does not include:

(i) a human services program, as defined in Section 62A-2-101;

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

(iii) a hospital that is owned by the state government, a state agency, or a political subdivision of the state, including:

(A) a state-owned teaching hospital; and

(B) the Utah State Hospital.

(6) "Medicare Cost Report" means CMS-2552-96 or CMS-2552-10, the cost report for

electronic filing of hospitals.

(7) "State plan amendment" means a change or update to the state Medicaid plan.

Section 111. Section **26B-3-702**, which is renumbered from Section 26-36d-102 is renumbered and amended to read:

[~~26-36d-102~~]. 26B-3-702. Legislative findings.

(1) The Legislature finds that there is an important state purpose to improve the access of Medicaid patients to quality care in Utah hospitals because of continuous decreases in state revenues and increases in enrollment under the Utah Medicaid program.

(2) The Legislature finds that in order to improve this access to those persons described in Subsection (1):

(a) the rates paid to Utah hospitals shall be adequate to encourage and support improved access; and

(b) adequate funding shall be provided to increase the rates paid to Utah hospitals providing services pursuant to the Utah Medicaid program.

Section 112. Section **26B-3-703**, which is renumbered from Section 26-36d-201 is renumbered and amended to read:

[~~26-36d-201~~]. 26B-3-703. Application of part.

(1) Other than for the imposition of the assessment described in this [~~chapter~~] part, nothing in this [~~chapter~~] part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under:

(a) Section 501(c), as amended, of the Internal Revenue Code;

(b) other applicable federal law;

(c) any state law;

(d) any ad valorem property taxes;

(e) any sales or use taxes; or

(f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by the state or any political subdivision, county, municipality, district, authority, or any agency or department thereof.

(2) All assessments paid under this [~~chapter~~] part may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This [~~chapter~~] part does not authorize a political subdivision of the state to:

(a) license a hospital for revenue;

(b) impose a tax or assessment upon hospitals; or

(c) impose a tax or assessment measured by the income or earnings of a hospital.

Section 113. Section **26B-3-704**, which is renumbered from Section 26-36d-202 is renumbered and amended to read:

[~~26-36d-202~~]. 26B-3-704. Assessment, collection, and payment of hospital provider assessment.

(1) A uniform, broad based, assessment is imposed on each hospital as defined in Subsection 26-36d-103(5)(a):

(a) in the amount designated in Section 26-36d-203; and

(b) in accordance with Section 26-36d-204.

(2) (a) The assessment imposed by this [~~chapter~~] part is due and payable on a quarterly basis in accordance with Section 26-36d-204.

(b) The collecting agent for this assessment is the department which is vested with the administration and enforcement of this [~~chapter~~] part, including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(i) implement and enforce the provisions of this act; and

(ii) audit records of a facility:

(A) that is subject to the assessment imposed by this [~~chapter~~] part; and

(B) does not file a Medicare Cost Report.

(c) The department shall forward proceeds from the assessment imposed by this [~~chapter~~] part to the state treasurer for deposit in the expendable special revenue fund as specified in Section 26-36d-207.

(3) The department may, by rule, extend the time for paying the assessment.

Section 114. Section **26B-3-705**, which is renumbered from Section 26-36d-203 is renumbered and amended to read:

[~~26-36d-203~~]. 26B-3-705. Calculation of assessment.

(1) (a) An annual assessment is payable on a quarterly basis for each hospital in an amount calculated at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) The uniform assessment rate shall be determined using the total number of hospital discharges for assessed hospitals divided into the total non-federal portion in an amount consistent with Section 26-36d-205 that is needed to support capitated rates for accountable care organizations for purposes of hospital services provided to Medicaid enrollees.

(c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to all assessed hospitals.

(d) The annual uniform assessment rate may not generate more than:

(i) $1,000,000 to offset Medicaid mandatory expenditures; and

(ii) the non-federal share to seed amounts needed to support capitated rates for accountable care organizations as provided for in Subsection (1)(b).

(2) (a) For each state fiscal year, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file. The hospital's discharge data will be derived as follows:

(i) for state fiscal year 2013, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2009, and June 30, 2010;

(ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2010, and June 30, 2011;

(iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2011, and June 30, 2012;

(iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2012, and June 30, 2013; and

(v) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.

(b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare Cost Report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(c) If a hospital is not certified by the Medicare program and is not required to file a Medicare Cost Report:

(i) the hospital shall submit to the division its applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (2)(c)(i); and

(iii) the failure to submit discharge information shall result in an audit of the hospital's records and a penalty equal to 5% of the calculated assessment.

(3) Except as provided in Subsection (4), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the assessment for each hospital shall be separately calculated by the department; and

(b) each separate hospital shall pay the assessment imposed by this [~~chapter~~] part.

(4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

Section 115. Section **26B-3-706**, which is renumbered from Section 26-36d-204 is renumbered and amended to read:

[~~26-36d-204~~]. 26B-3-706. Quarterly notice -- Collection.

Quarterly assessments imposed by this [~~chapter~~] part shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

Section 116. Section **26B-3-707**, which is renumbered from Section 26-36d-205 is renumbered and amended to read:

[~~26-36d-205~~]. 26B-3-707. Medicaid hospital adjustment under accountable care organization rates.

To preserve and improve access to hospital services, the division shall, for accountable care organization rates effective on or after April 1, 2013, incorporate into the accountable care organization rate structure calculation consistent with the certified actuarial rate range:

(1) $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

(2) an amount equal to the difference between payments made to hospitals by accountable care organizations for the Medicaid eligibility categories covered in Utah before January 1, 2019, based on submitted encounter data and the maximum amount that could be paid for those services using Medicare payment principles to be used for directed payments to hospitals for outpatient services.

Section 117. Section **26B-3-708**, which is renumbered from Section 26-36d-206 is renumbered and amended to read:

[~~26-36d-206~~]. 26B-3-708. Penalties and interest.

(1) A facility that fails to pay any assessment or file a return as required under this [~~chapter~~] part, within the time required by this [~~chapter~~] part, shall pay, in addition to the assessment, penalties and interest established by the department.

(2) (a) Consistent with Subsection (2)(b), the department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish reasonable penalties and interest for the violations described in Subsection (1).

(b) If a hospital fails to timely pay the full amount of a quarterly assessment, the department shall add to the assessment:

(i) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:

(A) any unpaid quarterly assessment; and

(B) any unpaid penalty assessment.

(c) Upon making a record of its actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this part.

Section 118. Section **26B-3-709**, which is renumbered from Section 26-36d-208 is renumbered and amended to read:

[~~26-36d-208~~]. 26B-3-709. Repeal of assessment.

(1) The repeal of the assessment imposed by this [~~chapter~~] part shall occur upon the certification by the executive director of the department that the sooner of the following has occurred:

(a) the effective date of any action by Congress that would disqualify the assessment

imposed by this [~~chapter~~] part from counting toward state Medicaid funds available to be used to determine the federal financial participation;

(b) the effective date of any decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government that has the effect of:

(i) disqualifying the assessment from counting towards state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creating for any reason a failure of the state to use the assessments for the Medicaid program as described in this [~~chapter~~] part;

(c) the effective date of:

(i) an appropriation for any state fiscal year from the General Fund for hospital payments under the state Medicaid program that is less than the amount appropriated for state fiscal year 2012;

(ii) the annual revenues of the state General Fund budget return to the level that was appropriated for fiscal year 2008;

(iii) a division change in rules that reduces any of the following below July 1, 2011, payments:

(A) aggregate hospital inpatient payments;

(B) adjustment payment rates; or

(C) any cost settlement protocol; or

(iv) a division change in rules that reduces the aggregate outpatient payments below July 1, 2011, payments; and

(d) the sunset of this [~~chapter~~] part in accordance with Section 63I-1-226.

(2) If the assessment is repealed under Subsection (1), money in the fund that was derived from assessments imposed by this [~~chapter~~] part, before the determination made under Subsection (1), shall be disbursed under Section 26-36d-205 to the extent federal matching is not reduced due to the impermissibility of the assessments. Any funds remaining in the special revenue fund shall be refunded to the hospitals in proportion to the amount paid by each hospital.

Section 119. Section **26B-3-801**, which is renumbered from Section 26-37a-102 is renumbered and amended to read:

Part 8. Ambulance Service Provider Assessment

[~~26-37a-102~~]. 26B-3-801. Definitions.

As used in this [~~chapter~~] part:

(1) "Ambulance service provider" means:

(a) an ambulance provider as defined in Section [~~26-8a-102~~] 26B-2-XXX; or

(b) a non-911 service provider as defined in Section [~~26-8a-102~~] 26B-2-XXX.

(2) "Assessment" means the Medicaid ambulance service provider assessment established by this [~~chapter~~] part.

(3) "Division" means the Division of Health Care Financing within the department.

(4) "Non-federal portion" means the non-federal share the division needs to seed amounts that will support fee-for-service ambulance service provider rates, as described in Section 26-37a-105.

(5) "Total transports" means the number of total ambulance transports applicable to a given fiscal year, as determined under Subsection 26-37a-104(5).

Section 120. Section **26B-3-802**, which is renumbered from Section 26-37a-103 is renumbered and amended to read:

[~~26-37a-103~~]. 26B-3-802. Assessment, collection, and payment of ambulance service provider assessment.

(1) An ambulance service provider shall pay an assessment to the division:

(a) in the amount designated in Section 26-37a-104;

(b) in accordance with this [~~chapter~~] part;

(c) quarterly, on a day determined by the division by rule made under Subsection (2)(b); and

(d) no more than 15 business days after the day on which the division issues the ambulance service provider notice of the assessment.

(2) The division shall:

(a) collect the assessment described in Subsection (1);

(b) determine, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, standards and procedures for implementing and enforcing the provisions of this [~~chapter~~] part; and

(c) transfer assessment proceeds to the state treasurer for deposit into the Ambulance

Service Provider Assessment Expendable Revenue Fund created in Section [~~26-37a-107~~] 26B-1-XXX.

Section 121. Section **26B-3-803**, which is renumbered from Section 26-37a-104 is renumbered and amended to read:

[~~26-37a-104~~]. 26B-3-803. Calculation of assessment.

(1) The division shall calculate a uniform assessment per transport as described in this section.

(2) The assessment due from a given ambulance service provider equals the non-federal portion divided by total transports, multiplied by the number of transports for the ambulance service provider.

(3) The division shall apply any quarterly changes to the assessment rate, calculated as described in Subsection (2), uniformly to all assessed ambulance service providers.

(4) The assessment may not generate more than the total of:

(a) an annual amount of $20,000 to offset Medicaid administration expenses; and

(b) the non-federal portion.

(5) (a) For each state fiscal year, the division shall calculate total transports using data from the Emergency Medical System as follows:

(i) for state fiscal year 2016, the division shall use ambulance service provider transports during the 2014 calendar year; and

(ii) for a fiscal year after 2016, the division shall use ambulance service provider transports during the calendar year ending 18 months before the end of the fiscal year.

(b) If an ambulance service provider fails to submit transport information to the Emergency Medical System, the division may audit the ambulance service provider to determine the ambulance service provider's transports for a given fiscal year.

Section 122. Section **26B-3-804**, which is renumbered from Section 26-37a-105 is renumbered and amended to read:

[~~26-37a-105~~]. 26B-3-804. Medicaid ambulance service provider adjustment under fee-for-service rates.

The division shall, if the assessment imposed by this [~~chapter~~] part is approved by the Centers for Medicare and Medicaid Services, for fee-for-service rates effective on or after July 1, 2015, reimburse an ambulance service provider in an amount up to the Emergency Medical

Services Ambulance Rates adopted annually by the department.

Section 123. Section **26B-3-805**, which is renumbered from Section 26-37a-106 is renumbered and amended to read:

[~~26-37a-106~~]. 26B-3-805. Penalties.

The division shall require an ambulance service provider that fails to pay an assessment due under this [~~chapter~~] part to pay the division, in addition to the assessment, a penalty determined by the division by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 124. Section **26B-3-806**, which is renumbered from Section 26-37a-108 is renumbered and amended to read:

[~~26-37a-108~~]. 26B-3-806. Repeal of assessment.

(1) This [~~chapter~~] part is repealed when, as certified by the executive director of the department, any of the following occurs:

(a) an action by Congress that disqualifies the assessment imposed by this [~~chapter~~] part from state Medicaid funds available to be used to determine the federal financial participation takes legal effect; or

(b) an action, decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state or federal government takes effect that:

(i) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creates for any reason a failure of the state to use the assessments for the Medicaid program as described in this [~~chapter~~] part.

(2) If this [~~chapter~~] part is repealed under Subsection (1):

(a) money in the Ambulance Service Provider Assessment Expendable Revenue Fund that was derived from assessments imposed by this [~~chapter~~] part, deposited before the determination made under Subsection (1), shall be disbursed under Section [~~26-37a-107~~] 26B-3-XXX to the extent federal matching is not reduced due to the impermissibility of the assessments; and

(b) any funds remaining in the special revenue fund shall be refunded to each ambulance service provider in proportion to the amount paid by the ambulance service provider.

Section 125. Section **26B-3-901**, which is renumbered from Section 26-40-102 is renumbered and amended to read:

Part 9. Utah Children's Health Insurance Program

[~~26-40-102~~]. 26B-3-901. Definitions.

As used in this [~~chapter~~] part:

(1) "Child" means [~~a person who is under 19 years of age~~] an individual who is younger than 19 years old.

(2) "Eligible child" means a child who qualifies for enrollment in the program as provided in Section [~~26-40-105~~] 26B-3-904.

(3) "Member" means a child enrolled in the program.

(4) "Plan" means the department's plan submitted to the United States Department of Health and Human Services pursuant to 42 U.S.C. Sec. 1397ff.

(5) "Program" means the Utah Children's Health Insurance Program created by this chapter.

Section 126. Section **26B-3-902**, which is renumbered from Section 26-40-103 is renumbered and amended to read:

[~~26-40-103~~]. 26B-3-902. Creation and administration of the Utah Children's Health Insurance Program.

(1) There is created the Utah Children's Health Insurance Program to be administered by the department in accordance with the provisions of:

(a) this chapter; and

(b) the State Children's Health Insurance Program, 42 U.S.C. Sec. 1397aa et seq.

(2) The department shall:

(a) prepare and submit the state's children's health insurance plan before May 1, 1998, and any amendments to the federal Department of Health and Human Services in accordance with 42 U.S.C. Sec. 1397ff; and

(b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act regarding:

(i) eligibility requirements consistent with Section [~~26-18-3~~] 26B-3-108;

(ii) program benefits;

(iii) the level of coverage for each program benefit;

(iv) cost-sharing requirements for members, which may not:

(A) exceed the guidelines set forth in 42 U.S.C. Sec. 1397ee; or

(B) impose deductible, copayment, or coinsurance requirements on a member for well-child, well-baby, and immunizations;

(v) the administration of the program; and

(vi) a requirement that:

(A) members in the program shall participate in the electronic exchange of clinical health records established in accordance with Section [~~26-1-37~~] 26B-X-XXX unless the member opts out of participation;

(B) prior to enrollment in the electronic exchange of clinical health records the member shall receive notice of the enrollment in the electronic exchange of clinical health records and the right to opt out of participation at any time; and

(C) beginning July 1, 2012, when the program sends enrollment or renewal information to the member and when the member logs onto the program's website, the member shall receive notice of the right to opt out of the electronic exchange of clinical health records.

Section 127. Section **26B-3-903**, which is renumbered from Section 26-40-105 is renumbered and amended to read:

[~~26-40-105~~]. 26B-3-903. Eligibility.

(1) A child is eligible to enroll in the program if the child:

(a) is a bona fide Utah resident;

(b) is a citizen or legal resident of the United States;

(c) is under 19 years of age;

(d) does not have access to or coverage under other health insurance, including any coverage available through a parent or legal guardian's employer;

(e) is ineligible for Medicaid benefits;

(f) resides in a household whose gross family income, as defined by rule, is at or below 200% of the federal poverty level; and

(g) is not an inmate of a public institution or a patient in an institution for mental diseases.

(2) A child who qualifies for enrollment in the program under Subsection (1) may not be denied enrollment due to a diagnosis or pre-existing condition.

(3) (a) The department shall determine eligibility and send notification of the eligibility decision within 30 days after receiving the application for coverage.

(b) If the department cannot reach a decision because the applicant fails to take a required action, or because there is an administrative or other emergency beyond the department's control, the department shall:

(i) document the reason for the delay in the applicant's case record; and

(ii) inform the applicant of the status of the application and time frame for completion.

(4) The department may not close enrollment in the program for a child who is eligible to enroll in the program under the provisions of Subsection (1).

(5) The program shall:

(a) apply for grants to make technology system improvements necessary to implement a simplified enrollment and renewal process in accordance with Subsection (5)(b); and

(b) if funding is available, implement a simplified enrollment and renewal process.

Section 128. Section **26B-3-904**, which is renumbered from Section 26-40-106 is renumbered and amended to read:

[~~26-40-106~~]. 26B-3-904. Program benefits.

(1) Except as provided in Subsection (3), medical and dental program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, as follows:

(a) medical program benefits, including behavioral health care benefits, shall be benchmarked effective July 1, 2019, and on July 1 every third year thereafter, to:

(i) be substantially equal to a health benefit plan with the largest insured commercial enrollment offered by a health maintenance organization in the state; and

(ii) comply with the Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343; and

(b) dental program benefits shall be benchmarked effective July 1, 2019, and on July 1 every third year thereafter in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, to be substantially equal to a dental benefit plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the state, except that the utilization review mechanism for orthodontia shall be based on medical necessity.

(2) On or before July 1 of each year, the department shall publish the benchmark for

dental program benefits established under Subsection (1)(b).

(3) The program benefits:

(a) for enrollees who are at or below 100% of the federal poverty level are exempt from the benchmark requirements of Subsections (1) and (2); and

(b) shall include treatment for autism spectrum disorder as defined in Section 31A-22-642, which:

(i) shall include coverage for applied behavioral analysis; and

(ii) if the benchmark described in Subsection (1)(a) does not include the coverage described in this Subsection (3)(b), the department shall exclude from the benchmark described in Subsection (1)(a) for any purpose other than providing benefits under the program.

Section 129. Section **26B-3-905**, which is renumbered from Section 26-40-107 is renumbered and amended to read:

[~~26-40-107~~]. 26B-3-905. Limitation of benefits.

Abortion is not a covered benefit, except as provided in 42 U.S.C. Sec. 1397ee.

Section 130. Section **26B-3-906**, which is renumbered from Section 26-40-108 is renumbered and amended to read:

[~~26-40-108~~]. 26B-3-906. Funding.

(1) The program shall be funded by federal matching funds received under, together with state matching funds required by, 42 U.S.C. Sec. 1397ee.

(2) Program expenditures in the following categories may not exceed 10% in the aggregate of all federal payments pursuant to 42 U.S.C. Sec. 1397ee:

(a) other forms of child health assistance for children with gross family incomes below 200% of the federal poverty level;

(b) other health services initiatives to improve low-income children's health;

(c) outreach program expenditures; and

(d) administrative costs.

Section 131. Section **26B-3-907**, which is renumbered from Section 26-40-109 is renumbered and amended to read:

[~~26-40-109~~]. 26B-3-907. Evaluation.

The department shall develop performance measures and annually evaluate the program's performance.

Section 132. Section **26B-3-908**, which is renumbered from Section 26-40-110 is renumbered and amended to read:

[~~26-40-110~~]. 26B-3-908. Managed care -- Contracting for services.

(1) Program benefits provided to a member under the program, as described in Section [~~26-40-106~~] 26B-3-904, shall be delivered by a managed care organization if the department determines that adequate services are available where the member lives or resides.

(2) The department may contract with a managed care organization to provide program benefits. The department shall evaluate a potential contract with a managed care organization based on:

(a) the managed care organization's:

(i) ability to manage medical expenses, including mental health costs;

(ii) proven ability to handle accident and health insurance;

(iii) efficiency of claim paying procedures;

(iv) proven ability for managed care and quality assurance;

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) estimated total charges for administering the pool;

(viii) ability to administer the pool in a cost-efficient manner;

(ix) ability to provide adequate providers and services in the state; and

(x) ability to meet quality measures for emergency room use and access to primary care established by the department under Subsection [~~26-18-408~~] 26B-3-904(4); and

(b) other factors established by the department.

(3) The department may enter into separate managed care organization contracts to provide dental benefits required by Section [~~26-40-106~~] 26B-3-904.

(4) The department's contract with a managed care organization for the program's benefits shall include risk sharing provisions in which the plan shall accept at least 75% of the risk for any difference between the department's premium payments per member and actual medical expenditures.

(5) (a) The department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1) if no managed care organization is willing to contract with the department or the department determines no

managed care organization meets the criteria established under Subsection (2).

(b) In accordance with Section 49-20-201, a contract awarded under Subsection (5)(a) is not subject to the risk sharing required by Subsection (4).

Section 133. Section **26B-3-909**, which is renumbered from Section 26-40-115 is renumbered and amended to read:

[~~26-40-115~~]. 26B-3-909. State contractor -- Employee and dependent health benefit plan coverage.

(1) For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5b-607, 63C-9-403, 72-6-107.5, and 79-2-404, "qualified health coverage" means, at the time the contract is entered into or renewed:

(a) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of:

(i) the benchmark plan determined by the program under Subsection 26-40-106(1)(a); and

(ii) a contribution level at which the employer pays at least 50% of the premium or contribution amounts for the employee and the dependents of the employee who reside or work in the state; or

(b) a federally qualified high deductible health plan that, at a minimum:

(i) has a deductible that is:

(A) the lowest deductible permitted for a federally qualified high deductible health plan; or

(B) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(ii) has an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(iii) provides that the employer pays 60% of the premium or contribution amounts for the employee and the dependents of the employee who work or reside in the state.

(2) The department shall:

(a) on or before July 1, 2016:

(i) determine the commercial equivalent of the benchmark plan described in Subsection (1)(a); and

(ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i) on the department's website, noting the date posted; and

(b) update the posted commercially equivalent benchmark plan annually and at the time of any change in the benchmark.

Section 134. Section **26B-3-1001**, which is renumbered from Section 26-19-102 is renumbered and amended to read:

Part 10. Medical Benefits Recovery

[~~26-19-102~~]. 26B-3-1001. Definitions.

As used in this [~~chapter~~] part:

(1) "Annuity" shall have the same meaning as provided in Section 31A-1-301.

(2) "Care facility" means:

(a) a nursing facility;

(b) an intermediate care facility for an individual with an intellectual disability; or

(c) any other medical institution.

(3) "Claim" means:

(a) a request or demand for payment; or

(b) a cause of action for money or damages arising under any law.

(4) "Employee welfare benefit plan" means a medical insurance plan developed by an employer under 29 U.S.C. [~~Section~~] Sec. 1001, et seq., the Employee Retirement Income Security Act of 1974 as amended.

(5) "Health insurance entity" means:

(a) an insurer;

(b) a person who administers, manages, provides, offers, sells, carries, or underwrites health insurance, as defined in Section 31A-1-301;

(c) a self-insured plan;

(d) a group health plan, as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(e) a service benefit plan;

(f) a managed care organization;

(g) a pharmacy benefit manager;

(h) an employee welfare benefit plan; or

(i) a person who is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(6) "Inpatient" means an individual who is a patient and a resident of a care facility.

(7) "Insurer" includes:

(a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(b) a health maintenance organization; and

(c) any entity offering a health service benefit plan.

(8) "Medical assistance" means:

(a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and

(b) any other services provided for the benefit of a recipient by a prepaid health care delivery system under contract with the department.

(9) "Office of Recovery Services" means the Office of Recovery Services within the Department of Human Services.

(10) "Provider" means a person or entity who provides services to a recipient.

(11) "Recipient" means:

(a) an individual who has applied for or received medical assistance from the state;

(b) the guardian, conservator, or other personal representative of an individual under Subsection (11)(a) if the individual is a minor or an incapacitated person; or

(c) the estate and survivors of an individual under Subsection (11)(a), if the individual is deceased.

(12) "Recovery estate" means, regarding a deceased recipient:

(a) all real and personal property or other assets included within a decedent's estate as defined in Section 75-1-201;

(b) the decedent's augmented estate as defined in Section 75-2-203; and

(c) that part of other real or personal property in which the decedent had a legal interest at the time of death including assets conveyed to a survivor, heir, or assign of the decedent

through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(13) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(14) "TEFRA lien" means a lien, authorized under the Tax Equity and Fiscal Responsibility Act of 1982, against the real property of an individual prior to the individual's death, as described in 42 U.S.C. Sec. 1396p.

(15) "Third party" includes:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and

(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.

(16) "Trust" shall have the same meaning as provided in Section 75-1-201.

Section 135. Section **26B-3-1002**, which is renumbered from Section 26-19-103 is renumbered and amended to read:

[~~26-19-103~~]. 26B-3-1002. Program established by department -- Promulgation of rules.

(1) The department shall establish and maintain a program for the recoupment of medical assistance.

(2) The department may promulgate rules to implement the purposes of this chapter.

Section 136. Section **26B-3-1003**, which is renumbered from Section 26-19-201 is renumbered and amended to read:

[~~26-19-201~~]. 26B-3-1003. Assignment of rights to benefits.

(1) (a) Except as provided in Subsection [~~26-19-401~~] 26B-3-1009(1), to the extent that

medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third-party otherwise payable to or on behalf of a recipient are assigned by operation of law to the department if the department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient.

(b) The assignment:

(i) authorizes the department to submit its claim to the third-party and authorizes payment of benefits directly to the department; and

(ii) is effective for all medical assistance.

(2) The department may recover the assigned benefits or payments in accordance with Section [~~26-19-401~~] 26B-3-1009 and as otherwise provided by law.

(3) (a) The assignment of benefits includes medical support and third-party payments ordered, decreed, or adjudged by any court of this state or any other state or territory of the United States.

(b) The assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment.

(4) When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the department are a reimbursement to the department.

Section 137. Section **26B-3-1004**, which is renumbered from Section 26-19-301 is renumbered and amended to read:

[~~26-19-301~~]. 26B-3-1004. Health insurance entity -- Duties related to state claims for Medicaid payment or recovery.

As a condition of doing business in the state, a health insurance entity shall:

(1) with respect to an individual who is eligible for, or is provided, medical assistance under the state plan, upon the request of the [~~Department of Health~~] department, provide information to determine:

(a) during what period the individual, or the spouse or dependent of the individual, may be or may have been, covered by the health insurance entity; and

(b) the nature of the coverage that is or was provided by the health insurance entity described in Subsection (1)(a), including the name, address, and identifying number of the plan;

(2) accept the state's right of recovery and the assignment to the state of any right of an individual to payment from a party for an item or service for which payment has been made under the state plan;

(3) respond to any inquiry by the [~~Department of Health~~] department regarding a claim for payment for any health care item or service that is submitted no later than three years after the day on which the health care item or service is provided; and

(4) not deny a claim submitted by the [~~Department of Health~~] department solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to present proper documentation at the point-of-sale that is the basis for the claim, if:

(a) the claim is submitted no later than three years after the day on which the item or service is furnished; and

(b) any action by the [~~Department of Health~~] department to enforce the rights of the state with respect to the claim is commenced no later than six years after the day on which the claim is submitted.

Section 138. Section **26B-3-1005**, which is renumbered from Section 26-19-302 is renumbered and amended to read:

[~~26-19-302~~]. 26B-3-1005. Insurance policies not to deny or reduce benefits of individuals eligible for state medical assistance -- Exemptions.

(1) A policy of accident or sickness insurance may not contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving medical assistance from the state.

(2) An association, corporation, or organization may not deliver, issue for delivery, or renew any subscriber's contract which contains any provisions denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance from the state.

(3) An association, corporation, business, or organization authorized to do business in this state and which provides or pays for any health care benefits may not deny or reduce benefits because services are rendered to a beneficiary who is eligible for or receiving medical assistance from the state.

(4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees' Health Program, administered by the Utah State Retirement Board, is not required to reimburse

any agency of state government for custodial care which the agency provides, through its staff or facilities, to members of the Utah State Public Employees' Health Program.

Section 139. Section **26B-3-1006**, which is renumbered from Section 26-19-303 is renumbered and amended to read:

[~~26-19-303~~]. 26B-3-1006. Availability of insurance policy.

If the third party does not pay the department's claim or lien within 30 days from the date the claim or lien is received, the third party shall:

(1) provide a written explanation if the claim is denied;

(2) specifically describe and request any additional information from the department that is necessary to process the claim; and

(3) provide the department or its agent a copy of any relevant or applicable insurance or benefit policy.

Section 140. Section **26B-3-1007**, which is renumbered from Section 26-19-304 is renumbered and amended to read:

[~~26-19-304~~]. 26B-3-1007. Employee benefit plans.

As allowed pursuant to 29 U.S.C. Section 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan based on the fact that the individual is eligible for or is provided services under the state plan.

Section 141. Section **26B-3-1008**, which is renumbered from Section 26-19-305 is renumbered and amended to read:

[~~26-19-305~~]. 26B-3-1008. Statute of limitations -- Survival of right of action -- Insurance policy not to limit time allowed for recovery.

(1) (a) Subject to Subsection (6), action commenced by the department under this [~~chapter~~] part against a health insurance entity shall be commenced within:

(i) subject to Subsection (7), six years after the day on which the department submits the claim for recovery or payment for the health care item or service upon which the action is based; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(b) An action against any other third party, the recipient, or anyone to whom the proceeds are payable shall be commenced within:

(i) four years after the date of the injury or onset of the illness; or

(ii) six months after the date of the last payment for medical assistance, whichever is later.

(2) The death of the recipient does not abate any right of action established by this chapter.

(3) (a) No insurance policy issued or renewed after June 1, 1981, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than 24 months from the date the provider furnishes services or goods to the recipient.

(b) No insurance policy issued or renewed after April 30, 2007, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than that described in Subsection (1)(a).

(4) The provisions of this section do not apply to Section [~~26-19-405 or Part 5, TEFRA Liens~~] 26B-3-1013 or Sections 26B-3-1015 through 26B-3-1023.

(5) The provisions of this section supercede any other sections regarding the time limit in which an action shall be commenced, including Section 75-7-509.

(6) (a) Subsection (1)(a) extends the statute of limitations on a cause of action described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.

(b) Subsection (1)(a) does not revive a cause of action that was time-barred on or before April 30, 2007.

(7) An action described in Subsection (1)(a) may not be commenced if the claim for recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after the day on which the health care item or service upon which the claim is based was provided.

Section 142. Section **26B-3-1009**, which is renumbered from Section 26-19-401 is renumbered and amended to read:

[~~26-19-401~~]. 26B-3-1009. Recovery of medical assistance from third party -- Lien -- Notice -- Action -- Compromise or waiver -- Recipient's right to action protected.

(1) (a) Except as provided in Subsection (1)(c), if the department provides or becomes

obligated to provide medical assistance to a recipient that a third-party is obligated to pay for, the department may recover the medical assistance directly from the third-party.

(b) (i) A claim under Subsection (1)(a) or Section [~~26-19-201~~] 26B-3-1003 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by the third-party.

(ii) The lien described in Subsection (1)(b)(i) has priority over all other claims to the proceeds, except claims for attorney fees and costs authorized under Subsection [~~26-19-403~~] 26B-3-1011(2)(c)(ii).

(c) (i) The department may not recover medical assistance under Subsection (1)(a) if:

(A) the third-party is obligated to pay the recipient for an injury to the recipient's child that occurred while the child was in the physical custody of the child's foster parent;

(B) the child's injury is a physical or mental impairment that requires ongoing medical attention, or limits activities of daily living, for at least one year;

(C) the third-party's payment to the recipient is placed in a trust, annuity, financial account, or other financial instrument for the benefit of the child; and

(D) the recipient makes reasonable efforts to mitigate any other medical assistance costs for the recipient to the state.

(ii) The department is responsible for any repayment to the federal government related to the medical assistance the department is prohibited from recovering under Subsection (1)(c)(i).

(2) (a) The department shall mail or deliver written notice of the department's claim or lien to the third-party at the third-party's principal place of business or last-known address.

(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury;

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.

(3) The department may commence an action on the department's claim or lien in the department's name, but the claim or lien is not enforceable as to a third-party unless:

(a) the third-party receives written notice of the department's claim or lien before the third-party settles with the recipient; or

(b) the department has evidence that the third party had knowledge that the department provided or was obligated to provide medical assistance.

(4) The department may:

(a) waive a claim or lien against a third party in whole or in part; or

(b) compromise, settle, or release a claim or lien.

(5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.

(6) Except as provided in Subsection (1)(c), the department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

Section 143. Section **26B-3-1010**, which is renumbered from Section 26-19-402 is renumbered and amended to read:

[~~26-19-402~~]. 26B-3-1010. Action by department -- Notice to recipient.

(1) (a) Within 30 days after commencing an action under Subsection [~~26-19-401~~] 26B-3-1009(3), the department shall give the recipient, the recipient's guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:

(i) personal service or certified mail to the last known address of the person receiving the notice; or

(ii) if no last-known address is available, by publishing a notice:

(A) once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides; and

(B) in accordance with Section 45-1-101 for three weeks.

(b) Proof of service shall be filed in the action.

(c) The recipient may intervene in the department's action at any time before trial.

(2) The notice required by Subsection (1) shall name the court in which the action is commenced and advise the recipient of:

(a) the right to intervene in the proceeding;

(b) the right to obtain a private attorney; and

(c) the department's right to recover medical assistance directly from the third party.

Section 144. Section **26B-3-1011**, which is renumbered from Section 26-19-403 is

renumbered and amended to read:

[~~26-19-403~~]. 26B-3-1011. Notice of claim by recipient -- Department response -- Conditions for proceeding -- Collection agreements.

(1) (a) A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, without the department's written consent as provided in Subsection (2)(b) or (4).

(b) For purposes of Subsection (1)(a), consent may be obtained if:

(i) a recipient who files a claim, or commences an action against a third party notifies the department in accordance with Subsection (1)(d) within 10 days of the recipient making the claim or commencing an action; or

(ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the department in accordance with Subsection (1)(d) of the recipient's claim:

(A) within 30 days after being retained by the recipient for that purpose; or

(B) within 30 days from the date the attorney either knew or should have known that the recipient received medical assistance from the department.

(c) Service of the notice of claim to the department shall be made by certified mail, personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the director of the Office of Recovery Services.

(d) The notice of claim shall include the following information:

(i) the name of the recipient;

(ii) the recipient's Social Security number;

(iii) the recipient's date of birth;

(iv) the name of the recipient's attorney if applicable;

(v) the name or names of individuals or entities against whom the recipient is making the claim, if known;

(vi) the name of the third party's insurance carrier, if known;

(vii) the date of the incident giving rise to the claim; and

(viii) a short statement identifying the nature of the recipient's claim.

(2) (a) Within 30 days of receipt of the notice of the claim required in Subsection (1), the department shall acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the following:

(i) if the department has a claim or lien pursuant to Section 26-19-401 or has become obligated to provide medical assistance; and

(ii) whether the department is denying or granting written consent in accordance with Subsection (1)(a).

(b) The department shall provide the recipient's attorney the opportunity to enter into a collection agreement with the department, with the recipient's consent, unless:

(i) the department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the department before the date the department received notice of the recipient's claim, and the agreement is documented in the department's record; or

(ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:

(A) failing to comply with the notice provisions of this section;

(B) failing or refusing to enter into a collection agreement;

(C) failing to comply with the terms of a collection agreement with the department; or

(D) failing to disburse funds owed to the state in accordance with this section.

(c) (i) The collection agreement shall be:

(A) consistent with this section and the attorney's obligation to represent the recipient and represent the state's claim; and

(B) state the terms under which the interests of the department may be represented in an action commenced by the recipient.

(ii) If the recipient's attorney enters into a written collection agreement with the department, or includes the department's claim in the recipient's claim or action pursuant to Subsection (4), the department shall pay attorney fees at the rate of 33.3% of the department's total recovery and shall pay a proportionate share of the litigation expenses directly related to the action.

(d) The department is not required to enter into a collection agreement with the

recipient's attorney for collection of personal injury protection under Subsection 31A-22-302(2).

(3) (a) If the department receives notice pursuant to Subsection (1), and notifies the recipient and the recipient's attorney that the department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against the third party if the recipient excludes from the claim:

(i) any medical expenses paid by the department; or

(ii) any medical costs for which the department is obligated to provide medical assistance.

(b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the department's claim for expenses under Subsection (3)(a)(i) or (ii).

(4) If the department receives notice pursuant to Subsection (1), and does not respond within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

(a) may proceed with the recipient's claim or action against the third party;

(b) may include the state's claim in the recipient's claim or action; and

(c) may not negotiate, compromise, settle, or waive the department's claim without the department's consent.

Section 145. Section **26B-3-1012**, which is renumbered from Section 26-19-404 is renumbered and amended to read:

[~~26-19-404~~]. 26B-3-1012. Department's right to intervene -- Department's interests protected -- Remitting funds -- Disbursements -- Liability and penalty for noncompliance.

(1) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.

(2) (a) If the recipient proceeds without complying with the provisions of Section 26-19-403, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.

(b) The department:

(i) may recover in full from the recipient, or any party to which the proceeds were made payable, all medical assistance that the department has provided; and

(ii) retains its right to commence an independent action against the third party, subject to Subsection [~~26-19-401~~] 26B-3-1009(3).

(3) Any amounts assigned to and recoverable by the department pursuant to Sections [~~26-19-201 and 26-19-401~~] 26B-3-1003 and 26B-3-1009 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.

(4) (a) Any amounts assigned to and recoverable by the department pursuant to Sections [~~26-19-201 and 26-19-401~~] 26B-3-1003 and 26B-3-1009 collected directly by the recipient's attorney shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.

(b) The date by which the funds shall be remitted to the department may be modified based on agreement between the department and the recipient's attorney.

(c) The department's consent to another date for remittance may not be unreasonably withheld.

(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(5) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:

(a) the amount of the department's claim or lien pursuant to Subsection (1);

(b) a penalty equal to 10% of the amount of the department's claim; and

(c) attorney fees and litigation expenses related to recovering the department's claim.

Section 146. Section **26B-3-1013**, which is renumbered from Section 26-19-405 is renumbered and amended to read:

[~~26-19-405~~]. 26B-3-1013. Estate and trust recovery.

(1) (a) Except as provided in Subsection (1)(b), upon a recipient's death, the department may recover from the recipient's recovery estate and any trust, in which the recipient is the grantor and a beneficiary, medical assistance correctly provided for the benefit of the recipient when the recipient was 55 years of age or older.

(b) The department may not make an adjustment or a recovery under Subsection (1)(a):

(i) while the deceased recipient's spouse is still living; or

(ii) if the deceased recipient has a surviving child who is:

(A) under age 21; or

(B) blind or disabled, as defined in the state plan.

(2) (a) The amount of medical assistance correctly provided for the benefit of a recipient and recoverable under this section is a lien against the deceased recipient's recovery estate or any trust when the recipient is the grantor and a beneficiary.

(b) The lien holds the same priority as reasonable and necessary medical expenses of the last illness as provided in Section 75-3-805.

(3) (a) For a lien described in Subsection (2), the department shall provide notice in accordance with Section 38-12-102.

(b) Before final distribution, the department shall perfect the lien as follows:

(i) for an estate, by presenting the lien to the estate's personal representative in accordance with Section 75-3-804; and

(ii) for a trust, by presenting the lien to the trustee in accordance with Section 75-7-510.

(c) The department may file an amended lien before the entry of the final order to close the estate or trust.

(4) Claims against a deceased recipient's inter vivos trust shall be presented in accordance with Sections 75-7-509 and 75-7-510.

(5) Any trust provision that denies recovery for medical assistance is void at the time of its making.

(6) Nothing in this section affects the right of the department to recover Medicaid assistance before a recipient's death under Section [~~26-19-201 or Section 26-19-406~~] 26B-3-1003 or 26B-3-1009.

(7) A lien imposed under this section is of indefinite duration.

Section 147. Section **26B-3-1014**, which is renumbered from Section 26-19-406 is renumbered and amended to read:

[~~26-19-406~~]. 26B-3-1014. Recovery from recipient of incorrectly provided medical assistance.

The department may:

(1) recover medical assistance incorrectly provided, whether due to administrative or factual error or fraud, from the recipient or the recipient's recovery estate; and

(2) pursuant to a judgment, impose a lien against real property of the recipient.

Section 148. Section **26B-3-1015**, which is renumbered from Section 26-19-501 is renumbered and amended to read:

[~~26-19-501~~]. 26B-3-1015. TEFRA liens authorized -- Grounds for TEFRA liens -- Exemptions.

(1) Except as provided in Subsections (2) and (3), the department may impose a TEFRA lien on the real property of an individual for the amount of medical assistance provided for, or to, the individual while the individual is an inpatient in a care facility, if:

(a) the individual is an inpatient in a care facility;

(b) the individual is required, as a condition of receiving services under the state plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and

(c) the department determines that the individual cannot reasonably be expected to:

(i) be discharged from the care facility; and

(ii) return to the individual's home.

(2) The department may not impose a lien on the home of an individual described in Subsection (1), if any of the following individuals are lawfully residing in the home:

(a) the spouse of the individual;

(b) a child of the individual, if the child is:

(i) under 21 years of age; or

(ii) blind or permanently and totally disabled, as defined in Title 42 U.S.C. Sec. 1382c(a)(3)(F); or

(c) a sibling of the individual, if the sibling:

(i) has an equity interest in the home; and

(ii) resided in the home for at least one year immediately preceding the day on which the individual was admitted to the care facility.

(3) The department may not impose a TEFRA lien on the real property of an individual, unless:

(a) the individual has been an inpatient in a care facility for the 180-day period immediately preceding the day on which the lien is imposed;

(b) the department serves:

(i) a preliminary notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section [~~26-19-503~~] 26B-3-1017; and

(ii) a final notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section [~~26-19-504~~] 26B-3-1018; and

(c) (i) the individual does not file a timely request for review of the department's decision under Title 63G, Chapter 4, Administrative Procedures Act; or

(ii) the department's decision is upheld upon final review or appeal under Title 63G, Chapter 4, Administrative Procedures Act.

Section 149. Section **26B-3-1016**, which is renumbered from Section 26-19-502 is renumbered and amended to read:

[~~26-19-502~~]. 26B-3-1016. Presumption of permanency.

There is a rebuttable presumption that an individual who is an inpatient in a care facility cannot reasonably be expected to be discharged from a care facility and return to the individual's home, if the individual has been an inpatient in a care facility for a period of at least 180 consecutive days.

Section 150. Section **26B-3-1017**, which is renumbered from Section 26-19-503 is renumbered and amended to read:

[~~26-19-503~~]. 26B-3-1017. Preliminary notice of intent to impose a TEFRA lien.

(1) Prior to imposing a TEFRA lien on real property, the department shall serve a preliminary notice of intent to impose a TEFRA lien, on the individual described in Subsection [~~26-19-501~~] 26B-3-1015(1), who owns the property.

(2) The preliminary notice of intent shall:

(a) be served in person, or by certified mail, on the individual described in Subsection [~~26-19-501~~] 26B-3-1015(1), and, if the department is aware that the individual has a legally authorized representative, on the representative;

(b) include a statement indicating that, according to the department's records, the individual:

(i) meets the criteria described in Subsections [~~26-19-501~~] 26B-3-1015(1)(a) and (b);

(ii) has been an inpatient in a care facility for a period of at least 180 days immediately preceding the day on which the department provides the notice to the individual; and

(iii) is legally presumed to be in a condition where it cannot reasonably be expected that the individual will be discharged from the care facility and return to the individual's home;

(c) indicate that the department intends to impose a TEFRA lien on real property belonging to the individual;

(d) describe the real property that the TEFRA lien will apply to;

(e) describe the current amount of, and purpose of, the TEFRA lien;

(f) indicate that the amount of the lien may continue to increase as the individual continues to receive medical assistance;

(g) indicate that the individual may seek to prevent the TEFRA lien from being imposed on the real property by providing documentation to the department that:

(i) establishes that the individual does not meet the criteria described in Subsection [~~26-19-501~~] 26B-3-1015(1)(a) or (b);

(ii) establishes that the individual has not been an inpatient in a care facility for a period of at least 180 days;

(iii) rebuts the presumption described in Section [~~26-19-502~~] 26B-3-1016; or

(iv) establishes that the real property is exempt from imposition of a TEFRA lien under Subsection [~~26-19-501~~] 26B-3-1015(2);

(h) indicate that if the owner fails to provide the documentation described in Subsection (2)(g) within 30 days after the day on which the preliminary notice of intent is served, the department will issue a final notice of intent to impose a TEFRA lien on the real property and will proceed to impose the lien;

(i) identify the type of documentation that the owner may provide to comply with Subsection (2)(g);

(j) describe the circumstances under which a TEFRA lien is required to be released; and

(k) describe the circumstances under which the department may seek to recover the lien.

Section 151. Section **26B-3-1018**, which is renumbered from Section 26-19-504 is

renumbered and amended to read:

[~~26-19-504~~]. 26B-3-1018. Final notice of intent to impose a TEFRA lien.

(1) The department may issue a final notice of intent to impose a TEFRA lien on real property if:

(a) a preliminary notice of intent relating to the property is served in accordance with Section [~~26-19-503~~] 26B-3-1017;

(b) it is at least 30 days after the day on which the preliminary notice of intent was served; and

(c) the department has not received documentation or other evidence that adequately establishes that a TEFRA lien may not be imposed on the real property.

(2) The final notice of intent to impose a TEFRA lien on real property shall:

(a) be served in person, or by certified mail, on the individual described in Subsection [~~26-19-501~~] 26B-3-1015(1), who owns the property, and, if the department is aware that the individual has a legally authorized representative, on the representative;

(b) indicate that the department has complied with the requirements for filing the final notice of intent under Subsection (1);

(c) include a statement indicating that, according to the department's records, the individual:

(i) meets the criteria described in Subsections [~~26-19-501~~] 26B-3-1015(1)(a) and (b);

(ii) has been an inpatient in a care facility for a period of at least 180 days immediately preceding the day on which the department provides the notice to the individual; and

(iii) is legally presumed to be in a condition where it cannot reasonably be expected that the individual will be discharged from the care facility and return to the individual's home;

(d) indicate that the department intends to impose a TEFRA lien on real property belonging to the individual;

(e) describe the real property that the TEFRA lien will apply to;

(f) describe the current amount of, and purpose of, the TEFRA lien;

(g) indicate that the amount of the lien may continue to increase as the individual continues to receive medical assistance;

(h) describe the circumstances under which a TEFRA lien is required to be released;

(i) describe the circumstances under which the department may seek to recover the

lien;

(j) describe the right of the individual to challenge the decision of the department in an adjudicative proceeding; and

(k) indicate that failure by the individual to successfully challenge the decision of the department will result in the TEFRA lien being imposed.

Section 152. Section **26B-3-1019**, which is renumbered from Section 26-19-505 is renumbered and amended to read:

[~~26-19-505~~]. 26B-3-1019. Review of department decision.

An individual who has been served with a final notice of intent to impose a TEFRA lien under Section [~~26-19-504~~] 26B-3-1018 may seek agency or judicial review of that decision under Title 63G, Chapter 4, Administrative Procedures Act.

Section 153. Section **26B-3-1020**, which is renumbered from Section 26-19-506 is renumbered and amended to read:

[~~26-19-506~~]. 26B-3-1020. Dissolution and removal of TEFRA lien.

(1) A TEFRA lien shall dissolve and be removed by the department if the individual described in Subsection [~~26-19-501~~] 26B-3-1015(1):

(a) (i) is discharged from the care facility; and

(ii) returns to the individual's home; or

(b) provides sufficient documentation to the department that:

(i) rebuts the presumption described in Section [~~26-19-502~~] 26B-3-1016; or

(ii) any of the following individuals are lawfully residing in the individual's home:

(A) the spouse of the individual;

(B) a child of the individual, if the child is under 21 years of age or blind or permanently and totally disabled, as defined in Title 42 U.S.C. Sec. 1382c(a)(3)(F); or

(C) a sibling of the individual, if the sibling has an equity interest in the home and resided in the home for at least one year immediately preceding the day on which the individual was admitted to the care facility.

(2) An individual described in Subsection [~~26-19-501~~] 26B-3-1015(1)(a) may, at any time after the department has imposed a lien under this part, file a request for the department to remove the lien.

(3) A request filed under Subsection (2) shall be considered and reviewed pursuant to

Title 63G, Chapter 4, Administrative Procedures Act.

Section 154. Section **26B-3-1021**, which is renumbered from Section 26-19-507 is renumbered and amended to read:

[~~26-19-507~~]. 26B-3-1021. Expenditures included in lien -- Other proceedings.

(1) A TEFRA lien imposed on real property under this part includes all expenses relating to medical assistance provided or paid for under the state plan from the first day that the individual is placed in a care facility, regardless of when the lien is imposed or filed on the property.

(2) Nothing in this part affects or prevents the department from bringing or pursuing any other legally authorized action to recover medical assistance or to set aside a fraudulent or improper conveyance.

Section 155. Section **26B-3-1022**, which is renumbered from Section 26-19-508 is renumbered and amended to read:

[~~26-19-508~~]. 26B-3-1022. Contract with another government agency.

If the department contracts with another government agency to recover funds paid for medical assistance under this [~~chapter~~] part, that government agency shall be the sole agency that determines whether to impose or remove a TEFRA lien under this part.

Section 156. Section **26B-3-1023**, which is renumbered from Section 26-19-509 is renumbered and amended to read:

[~~26-19-509~~]. 26B-3-1023. Precedence of the Tax Equity and Fiscal Responsibility Act of 1982.

If any provision of this part conflicts with the requirements of the Tax Equity and Fiscal Responsibility Act of 1982 for imposing a lien against the property of an individual prior to the individual's death, under 42 U.S.C. Sec. 1396p, the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 take precedence and shall be complied with by the department.

Section 157. Section **26B-3-1024**, which is renumbered from Section 26-19-601 is renumbered and amended to read:

[~~26-19-601~~]. 26B-3-1024. Legal recognition of electronic claims records.

Pursuant to Title 46, Chapter 4, Uniform Electronic Transactions Act:

(1) a claim submitted to the department for payment may not be denied legal effect, enforceability, or admissibility as evidence in any court in any civil action because it is in electronic form; and

(2) a third party shall accept an electronic record of payments by the department for medical services on behalf of a recipient as evidence in support of the department's claim.

Section 158. Section **26B-3-1025**, which is renumbered from Section 26-19-602 is renumbered and amended to read:

[~~26-19-602~~]. 26B-3-1025. Direct payment to the department by third party.

(1) Any third party required to make payment to the department pursuant to this chapter shall make the payment directly to the department or its designee.

(2) The department may negotiate a payment or payment instrument it receives in connection with Subsection (1) without the cosignature or other participation of the recipient or any other party.

Section 159. Section **26B-3-1026**, which is renumbered from Section 26-19-603 is renumbered and amended to read:

[~~26-19-603~~]. 26B-3-1026. Attorney general or county attorney to represent department.

The attorney general or a county attorney shall represent the department in any action commenced under this [~~chapter~~] part.

Section 160. Section **26B-3-1027**, which is renumbered from Section 26-19-604 is renumbered and amended to read:

[~~26-19-604~~]. 26B-3-1027. Department's right to attorney fees and costs.

In any action brought by the department under this [~~chapter~~] part in which it prevails, the department shall recover along with the principal sum and interest, a reasonable attorney fee and costs incurred.

Section 161. Section **26B-3-1028**, which is renumbered from Section 26-19-605 is renumbered and amended to read:

[~~26-19-605~~]. 26B-3-1028. Application of provisions contrary to federal law prohibited.

In no event shall any provision contained in this chapter be applied contrary to existing

federal law.

Section 162. Section **26B-3-1101**, which is renumbered from Section 26-20-2 is renumbered and amended to read:

Part 11. Utah False Claims Act

[~~26-20-2~~]. 26B-3-1101. Definitions.

As used in this [~~chapter~~] part:

(1) "Benefit" means the receipt of money, goods, or any other thing of pecuniary value.

(2) "Claim" means any request or demand for money or property:

(a) made to any:

(i) employee, officer, or agent of the state;

(ii) contractor with the state; or

(iii) grantee or other recipient, whether or not under contract with the state; and

(b) if:

(i) any portion of the money or property requested or demanded was issued from or provided by the state; or

(ii) the state will reimburse the contractor, grantee, or other recipient for any portion of the money or property.

(3) "False statement" or "false representation" means a wholly or partially untrue statement or representation which is:

(a) knowingly made; and

(b) a material fact with respect to the claim.

(4) "Knowing" and "knowingly":

(a) for purposes of criminal prosecutions for violations of this chapter, is one of the culpable mental states described in Subsection 26-20-9(1); and

(b) for purposes of civil prosecutions for violations of this chapter, is the required culpable mental state as defined in Subsection 26-20-9.5(1).

(5) "Medical benefit" means a benefit paid or payable to a recipient or a provider under a program administered by the state under:

(a) Titles V and XIX of the federal Social Security Act;

(b) Title X of the federal Public Health Services Act;

(c) the federal Child Nutrition Act of 1966 as amended by P.L. 94-105; and

(d) any programs for medical assistance of the state.

(6) "Person" means an individual, corporation, unincorporated association, professional corporation, partnership, or other form of business association.

Section 163. Section **26B-3-1102**, which is renumbered from Section 26-20-3 is renumbered and amended to read:

[~~26-20-3~~]. 26B-3-1102. False statement or representation relating to medical benefits.

(1) A person may not make or cause to be made a false statement or false representation of a material fact in an application for medical benefits.

(2) A person may not make or cause to be made a false statement or false representation of a material fact for use in determining rights to a medical benefit.

(3) A person, who having knowledge of the occurrence of an event affecting the person's initial or continued right to receive a medical benefit or the initial or continued right of any other person on whose behalf the person has applied for or is receiving a medical benefit, may not conceal or fail to disclose that event with intent to obtain a medical benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.

Section 164. Section **26B-3-1103**, which is renumbered from Section 26-20-4 is renumbered and amended to read:

[~~26-20-4~~]. 26B-3-1103. Kickbacks or bribes prohibited.

(1) For purposes of this section, kickback or bribe:

(a) includes rebates, compensation, or any other form of remuneration which is:

(i) direct or indirect;

(ii) overt or covert; or

(iii) in cash or in kind; and

(b) does not include a rebate paid to the state under 42 U.S.C. Sec. 1396r-8 or any state supplemental rebates.

(2) A person may not solicit, offer, pay, or receive a kickback or bribe in return for or to induce:

(a) the purchasing, leasing, or ordering of any goods or services for which payment is or may be made in whole or in part pursuant to a medical benefit program; or

(b) the referral of an individual to another person for the furnishing of any goods or services for which payment is or may be made in whole or in part pursuant to a medical benefit program.

Section 165. Section **26B-3-1104**, which is renumbered from Section 26-20-5 is renumbered and amended to read:

[~~26-20-5~~]. 26B-3-1104. False statements or false representations relating to qualification of health institution or facility prohibited -- Felony.

(1) A person may not knowingly, intentionally, or recklessly make, induce, or seek to induce, the making of a false statement or false representation of a material fact with respect to the conditions or operation of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, as a hospital, skilled nursing facility, intermediate care facility, or home health agency.

(2) A person who violates this section is guilty of a second degree felony.

Section 166. Section **26B-3-1105**, which is renumbered from Section 26-20-6 is renumbered and amended to read:

[~~26-20-6~~]. 26B-3-1105. Conspiracy to defraud prohibited.

A person may not enter into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious, or fraudulent claim for a medical benefit.

Section 167. Section **26B-3-1106**, which is renumbered from Section 26-20-7 is renumbered and amended to read:

[~~26-20-7~~]. 26B-3-1106. False claims for medical benefits prohibited.

(1) A person may not make or present or cause to be made or presented to an employee or officer of the state a claim for a medical benefit:

(a) which is wholly or partially false, fictitious, or fraudulent;

(b) for services which were not rendered or for items or materials which were not delivered;

(c) which misrepresents the type, quality, or quantity of items or services rendered;

(d) representing charges at a higher rate than those charged by the provider to the general public;

(e) for items or services which the person or the provider knew were not medically

necessary in accordance with professionally recognized standards;

(f) which has previously been paid;

(g) for services also covered by one or more private sources when the person or provider knew of the private sources without disclosing those sources on the claim; or

(h) where a provider:

(i) unbundles a product, procedure, or group of procedures usually and customarily provided or performed as a single billable product or procedure into artificial components or separate procedures; and

(ii) bills for each component of the product, procedure, or group of procedures:

(A) as if they had been provided or performed independently and at separate times; and

(B) the aggregate billing for the components exceeds the amount otherwise billable for the usual and customary single product or procedure.

(2) In addition to the prohibitions in Subsection (1), a person may not:

(a) fail to credit the state for payments received from other sources;

(b) recover or attempt to recover payment in violation of the provider agreement from:

(i) a recipient under a medical benefit program; or

(ii) the recipient's family;

(c) falsify or alter with intent to deceive, any report or document required by state or federal law, rule, or Medicaid provider agreement;

(d) retain any unauthorized payment as a result of acts described by this section; or

(e) aid or abet the commission of any act prohibited by this section.

Section 168. Section **26B-3-1107**, which is renumbered from Section 26-20-8 is renumbered and amended to read:

[~~26-20-8~~]. 26B-3-1107. Knowledge of past acts not necessary to establish fact that false statement or representation knowingly made.

In prosecution under this chapter, it is not necessary to show that the person had knowledge of similar acts having been performed in the past on the part of persons acting on his behalf nor to show that the person had actual notice that the acts by the persons acting on his behalf occurred to establish the fact that a false statement or representation was knowingly made.

Section 169. Section **26B-3-1108**, which is renumbered from Section 26-20-9 is

renumbered and amended to read:

[~~26-20-9~~]. 26B-3-1108. Criminal penalties.

(1) (a) Except as provided in Subsection (1)(b) the culpable mental state required for a criminal violation of this chapter is knowingly, intentionally, or recklessly as defined in Section 76-2-103.

(b) The culpable mental state required for a criminal violation of this chapter for kickbacks and bribes under Section 26-20-4 is knowingly and intentionally as defined in Section 76-2-103.

(2) The punishment for a criminal violation of any provision of this chapter, except as provided under Section 26-20-5, is determined by the cumulative value of the funds or other benefits received or claimed in the commission of all violations of a similar nature, and not by each separate violation.

(3) Punishment for criminal violation of this chapter, except as provided under Section 26-20-5, is a felony of the second degree, felony of the third degree, class A misdemeanor, or class B misdemeanor based on the dollar amounts as prescribed by Subsection 76-6-412(1) for theft of property and services.

Section 170. Section **26B-3-1109**, which is renumbered from Section 26-20-9.5 is renumbered and amended to read:

[~~26-20-9.5~~]. 26B-3-1109. Civil penalties.

(1) The culpable mental state required for a civil violation of this chapter is "knowing" or "knowingly" which:

(a) means that person, with respect to information:

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(b) does not require a specific intent to defraud.

(2) Any person who violates this chapter shall, in all cases, in addition to other penalties provided by law, be required to:

(a) make full and complete restitution to the state of all damages that the state sustains because of the person's violation of this chapter;

(b) pay to the state its costs of enforcement of this chapter in that case, including the

cost of investigators, attorneys, and other public employees, as determined by the state; and

(c) pay to the state a civil penalty equal to:

(i) three times the amount of damages that the state sustains because of the person's violation of this chapter; and

(ii) not less than $5,000 or more than $10,000 for each claim filed or act done in violation of this chapter.

(3) Any civil penalties assessed under Subsection (2) shall be awarded by the court as part of its judgment in both criminal and civil actions.

(4) A criminal action need not be brought against a person in order for that person to be civilly liable under this section.

Section 171. Section **26B-3-1110**, which is renumbered from Section 26-20-10 is renumbered and amended to read:

[~~26-20-10~~]. 26B-3-1110. Revocation of license of assisted living facility -- Appointment of receiver.

(1) If the license of an assisted living facility is revoked for violation of this [~~chapter~~] part, the county attorney may file a petition with the district court for the county in which the facility is located for the appointment of a receiver.

(2) The district court shall issue an order to show cause why a receiver should not be appointed returnable within five days after the filing of the petition.

(3) (a) If the court finds that the facts warrant the granting of the petition, the court shall appoint a receiver to take charge of the facility.

(b) The court may determine fair compensation for the receiver.

(4) A receiver appointed pursuant to this section shall have the powers and duties prescribed by the court.

Section 172. Section **26B-3-1111**, which is renumbered from Section 26-20-11 is renumbered and amended to read:

[~~26-20-11~~]. 26B-3-1111. Presumption based on paid state warrant -- Value of medical benefits -- Repayment of benefits.

(1) In any civil or criminal action brought under this [~~chapter~~] part, a paid state warrant, made payable to the order of a party, creates a presumption that the party received funds from the state.

(2) In any civil or criminal action brought under this [~~chapter~~] part, the value of the benefits received shall be the ordinary or usual charge for similar benefits in the private sector.

(3) In any criminal action under this [~~chapter~~] part, the repayment of funds or other benefits obtained in violation of the provisions of this [~~chapter~~] part does not constitute a defense to, or grounds for dismissal of that action.

Section 173. Section **26B-3-1112**, which is renumbered from Section 26-20-12 is renumbered and amended to read:

[~~26-20-12~~]. 26B-3-1112. Violation of other laws.

(1) The provisions of this [~~chapter~~] part are:

(a) not exclusive, and the remedies provided for in this [~~chapter~~] part are in addition to any other remedies provided for under:

(i) any other applicable law; or

(ii) common law; and

(b) to be liberally construed and applied to:

(i) effectuate the chapter's remedial and deterrent purposes; and

(ii) serve the public interest.

(2) If any provision of this [~~chapter~~] part or the application of this chapter to any person or circumstance is held unconstitutional:

(a) the remaining provisions of this [~~chapter~~] part are not affected; and

(b) the application of this [~~chapter~~] part to other persons or circumstances are not affected.

Section 174. Section **26B-3-1113**, which is renumbered from Section 26-20-13 is renumbered and amended to read:

[~~26-20-13~~]. 26B-3-1113. Medicaid fraud enforcement.

(1) This [~~chapter~~] part shall be enforced in accordance with this section.

(2) The department is responsible for:

(a) (i) investigating and prosecuting suspected civil violations of this [~~chapter~~] part; or

(ii) referring suspected civil violations of this [~~chapter~~] part to the attorney general for investigation and prosecution; and

(b) promptly referring suspected criminal violations of this [~~chapter~~] part to the attorney general for criminal investigation and prosecution.

(3) The attorney general has:

(a) concurrent jurisdiction with the department for investigating and prosecuting suspected civil violations of this [~~chapter~~] part; and

(b) exclusive jurisdiction to investigate and prosecute all suspected criminal violations of this [~~chapter~~] part.

(4) The department and the attorney general share concurrent civil enforcement authority under this [~~chapter~~] part and may enter into an interagency agreement regarding the investigation and prosecution of violations of this [~~chapter~~] part in accordance with this section, the requirements of Title XIX of the federal Social Security Act, and applicable federal regulations.

(5) (a) Any violation of this chapter which comes to the attention of any state government officer or agency shall be reported to the attorney general or the department.

(b) All state government officers and agencies shall cooperate with and assist in any prosecution for violation of this [~~chapter~~] part.

Section 175. Section **26B-3-1114**, which is renumbered from Section 26-20-14 is renumbered and amended to read:

[~~26-20-14~~]. 26B-3-1114. Investigations -- Civil investigative demands.

(1) The attorney general may take investigative action under Subsection (2) if the attorney general has reason to believe that:

(a) a person has information or custody or control of documentary material relevant to the subject matter of an investigation of an alleged violation of this [~~chapter~~] part;

(b) a person is committing, has committed, or is about to commit a violation of this [~~chapter~~] part; or

(c) it is in the public interest to conduct an investigation to ascertain whether or not a person is committing, has committed, or is about to commit a violation of this [~~chapter~~] part.

(2) In taking investigative action, the attorney general may:

(a) require the person to file on a prescribed form a statement in writing, under oath or affirmation describing:

(i) the facts and circumstances concerning the alleged violation of this [~~chapter~~] part; and

(ii) other information considered necessary by the attorney general;

(b) examine under oath a person in connection with the alleged violation of this [~~chapter~~] part; and

(c) in accordance with Subsections (7) through (18), execute in writing, and serve on the person, a civil investigative demand requiring the person to produce the documentary material and permit inspection and copying of the material.

(3) The attorney general may not release or disclose information that is obtained under Subsection (2)(a) or (b), or any documentary material or other record derived from the information obtained under Subsection (2)(a) or (b), except:

(a) by court order for good cause shown;

(b) with the consent of the person who provided the information;

(c) to an employee of the attorney general or the department;

(d) to an agency of this state, the United States, or another state;

(e) to a special assistant attorney general representing the state in a civil action;

(f) to a political subdivision of this state; or

(g) to a person authorized by the attorney general to receive the information.

(4) The attorney general may use documentary material derived from information obtained under Subsection (2)(a) or (b), or copies of that material, as the attorney general determines necessary in the enforcement of this [~~chapter~~] part, including presentation before a court.

(5) (a) If a person fails to file a statement as required by Subsection (2)(a) or fails to submit to an examination as required by Subsection (2)(b), the attorney general may file in district court a complaint for an order to compel the person to within a period stated by court order:

(i) file the statement required by Subsection (2)(a); or

(ii) submit to the examination required by Subsection (2)(b).

(b) Failure to comply with an order entered under Subsection (5)(a) is punishable as contempt.

(6) A civil investigative demand shall:

(a) state the rule or statute under which the alleged violation of this [~~chapter~~] part is being investigated;

(b) describe the:

(i) general subject matter of the investigation; and

(ii) class or classes of documentary material to be produced with reasonable specificity to fairly indicate the documentary material demanded;

(c) designate a date within which the documentary material is to be produced; and

(d) identify an authorized employee of the attorney general to whom the documentary material is to be made available for inspection and copying.

(7) A civil investigative demand may require disclosure of any documentary material that is discoverable under the Utah Rules of Civil Procedure.

(8) Service of a civil investigative demand may be made by:

(a) delivering an executed copy of the demand to the person to be served or to a partner, an officer, or an agent authorized by appointment or by law to receive service of process on behalf of that person;

(b) delivering an executed copy of the demand to the principal place of business in this state of the person to be served; or

(c) mailing by registered or certified mail an executed copy of the demand addressed to the person to be served:

(i) at the person's principal place of business in this state; or

(ii) if the person has no place of business in this state, to the person's principal office or place of business.

(9) Documentary material demanded in a civil investigative demand shall be produced for inspection and copying during normal business hours at the office of the attorney general or as agreed by the person served and the attorney general.

(10) The attorney general may not produce for inspection or copying or otherwise disclose the contents of documentary material obtained pursuant to a civil investigative demand except:

(a) by court order for good cause shown;

(b) with the consent of the person who produced the information;

(c) to an employee of the attorney general or the department;

(d) to an agency of this state, the United States, or another state;

(e) to a special assistant attorney general representing the state in a civil action;

(f) to a political subdivision of this state; or

(g) to a person authorized by the attorney general to receive the information.

(11) (a) With respect to documentary material obtained pursuant to a civil investigative demand, the attorney general shall prescribe reasonable terms and conditions allowing such documentary material to be available for inspection and copying by the person who produced the material or by an authorized representative of that person.

(b) The attorney general may use such documentary material or copies of it as the attorney general determines necessary in the enforcement of this [~~chapter~~] part, including presentation before a court.

(12) (a) A person may file a complaint, stating good cause, to extend the return date for the demand or to modify or set aside the demand.

(b) A complaint under this Subsection (12) shall be filed in district court before the earlier of:

[~~(a)~~] (i) the return date specified in the demand; or

[~~(b)~~] (ii) the 20th day after the date the demand is served.

(13) Except as provided by court order, a person who has been served with a civil investigative demand shall comply with the terms of the demand.

(14) (a) A person who has committed a violation of this [~~chapter~~] part in relation to the Medicaid program in this state or to any other medical benefit program administered by the state has submitted to the jurisdiction of this state.

(b) Personal service of a civil investigative demand under this section may be made on the person described in Subsection (14)(a) outside of this state.

(15) This section does not limit the authority of the attorney general to conduct investigations or to access a person's documentary materials or other information under another state or federal law, the Utah Rules of Civil Procedure, or the Federal Rules of Civil Procedure.

(16) The attorney general may file a complaint in district court for an order to enforce the civil investigative demand if:

(a) a person fails to comply with a civil investigative demand; or

(b) copying and reproduction of the documentary material demanded:

(i) cannot be satisfactorily accomplished; and

(ii) the person refuses to surrender the documentary material.

(17) If a complaint is filed under Subsection (16), the court may determine the matter

presented and may enter an order to enforce the civil investigative demand.

(18) Failure to comply with a final order entered under Subsection (17) is punishable by contempt.

Section 176. Section **26B-3-1115**, which is renumbered from Section 26-20-15 is renumbered and amended to read:

[~~26-20-15~~]. 26B-3-1115. Limitation of actions -- Civil acts antedating this section -- Civil burden of proof -- Estoppel -- Joint civil liability -- Venue.

(1) An action under this [~~chapter~~] part may not be brought after the later of:

(a) six years after the date on which the violation was committed; or

(b) three years after the date an official of the state charged with responsibility to act in the circumstances discovers the violation, but in no event more than 10 years after the date on which the violation was committed.

(2) A civil action brought under this chapter may be brought for acts occurring prior to the effective date of this section if the limitations period set forth in Subsection (1) has not lapsed.

(3) In any civil action brought under this [~~chapter~~] part the state shall be required to prove by a preponderance of evidence, all essential elements of the cause of action including damages.

(4) Notwithstanding any other provision of law, a final judgment rendered in favor of the state in any criminal proceeding under this [~~chapter~~] part, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any civil action under this [~~chapter~~] part which involves the same transaction.

(5) Civil liability under this [~~chapter~~] part shall be joint and several for a violation committed by two or more persons.

(6) Any action brought by the state under this [~~chapter~~] part shall be brought in district court in Salt Lake County or in any county where the defendant resides or does business.

Section 177. Section **26B-8-101** is amended to read:

CHAPTER 8. HEALTH DATA, VITAL STATISTICS AND UTAH MEDICAL EXAMINER

Part 1. Vital Statistics

26B-8-101. Definitions.

[~~Reserved~~]

As used in this part:

(1) "Adoption document" means an adoption-related document filed with the office, a petition for adoption, a decree of adoption, an original birth certificate, or evidence submitted in support of a supplementary birth certificate.

(2) "Certified nurse midwife" means an individual who:

(a) is licensed to practice as a certified nurse midwife under Title 58, Chapter 44a, Nurse Midwife Practice Act; and

(b) has completed an education program regarding the completion of a certificate of death developed by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Custodial funeral service director" means a funeral service director who:

(a) is employed by a licensed funeral establishment; and

(b) has custody of a dead body.

(4) "Dead body" means a human body or parts of the human body from the condition of which it reasonably may be concluded that death occurred.

(5) "Decedent" means the same as dead body.

(6) "Dead fetus" means a product of human conception, other than those circumstances described in Subsection 76-7-301(1):

(a) of 20 weeks' gestation or more, calculated from the date the last normal menstrual period began to the date of delivery; and

(b) that was not born alive.

(7) "Declarant father" means a male who claims to be the genetic father of a child, and, along with the biological mother, signs a voluntary declaration of paternity to establish the child's paternity.

(8) "Dispositioner" means:

(a) a person designated in a written instrument, under Subsection 58-9-602(1), as having the right and duty to control the disposition of the decedent, if the person voluntarily acts as the dispositioner; or

(b) the next of kin of the decedent, if:

(i) (A) a person has not been designated as described in Subsection (8)(a); or

(B) the person described in Subsection (8)(a) is unable or unwilling to exercise the right and duty described in Subsection (8)(a); and

(ii) the next of kin voluntarily acts as the dispositioner.

(9) "Fetal remains" means:

(a) an aborted fetus as that term is defined in Section 26-21-33; or

(b) a miscarried fetus as that term is defined in Section 26-21-34.

(10) "File" means the submission of a completed certificate or other similar document, record, or report as provided under this part for registration by the state registrar or a local registrar.

(11) "Funeral service director" means the same as that term is defined in Section 58-9-102.

(12) "Health care facility" means the same as that term is defined in Section 26B-2-201.

(13) "Health care professional" means a physician, physician assistant, nurse practitioner, or certified nurse midwife.

(14) "Licensed funeral establishment" means:

(a) if located in Utah, a funeral service establishment, as that term is defined in Section 58-9-102, that is licensed under Title 58, Chapter 9, Funeral Services Licensing Act; or

(b) if located in a state, district, or territory of the United States other than Utah, a funeral service establishment that complies with the licensing laws of the jurisdiction where the establishment is located.

(15) "Live birth" means the birth of a child who shows evidence of life after the child is entirely outside of the mother.

(16) "Local registrar" means a person appointed under Subsection 26-2-3(3)(b).

(17) "Nurse practitioner" means an individual who:

(a) is licensed to practice as an advanced practice registered nurse under Title 58, Chapter 31b, Nurse Practice Act; and

(b) has completed an education program regarding the completion of a certificate of death developed by the department by administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(18) "Office" means the Office of Vital Records and Statistics within the department.

(19) "Physician" means a person licensed to practice as a physician or osteopath in this state under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(20) "Physician assistant" means an individual who:

(a) is licensed to practice as a physician assistant under Title 58, Chapter 70a, Utah Physician Assistant Act; and

(b) has completed an education program regarding the completion of a certificate of death developed by the department by administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(21) "Presumed father" means the father of a child conceived or born during a marriage as defined in Section 30-1-17.2.

(22) "Registration" or "register" means acceptance by the local or state registrar of a certificate and incorporation of the certificate into the permanent records of the state.

(23) "State registrar" means the state registrar of vital records appointed under Section 26B-8-102.

(24) "Vital records" means:

(a) registered certificates or reports of birth, death, fetal death, marriage, divorce, dissolution of marriage, or annulment;

(b) amendments to any of the registered certificates or reports described in Subsection (23)(a);

(c) an adoption document; and

(d) other similar documents.

(25) "Vital statistics" means the data derived from registered certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage, divorce, dissolution of marriage, or annulment.

Section 178. Section **26B-8-102**, which is renumbered from Section 26-2-3 is renumbered and amended to read:

[~~26-2-3~~]. 26B-8-102. Department duties and authority.

(1) As used in this section:

(a) "Compact" means the Compact for Interstate Sharing of Putative Father Registry

Information created in Section 78B-6-121.5, effective on May 10, 2016.

(b) "Putative father":

(i) means the same as that term is as defined in Section 78B-6-121.5; and

(ii) includes an unmarried biological father.

(c) "State registrar" means the state registrar of vital records appointed under Subsection (2)(e).

(d) "Unmarried biological father" means the same as that term is defined in Section 78B-6-103.

(2) The department shall:

(a) provide offices properly equipped for the preservation of vital records made or received under this [~~chapter~~] part;

(b) establish a statewide vital records system for the registration, collection, preservation, amendment, and certification of vital records and other similar documents required by this chapter and activities related to them, including the tabulation, analysis, and publication of vital statistics;

(c) prescribe forms for certificates, certification, reports, and other documents and records necessary to establish and maintain a statewide system of vital records;

(d) prepare an annual compilation, analysis, and publication of statistics derived from vital records; and

(e) appoint a state registrar to direct the statewide system of vital records.

(3) The department may:

(a) divide the state from time to time into registration districts; and

(b) appoint local registrars for registration districts who under the direction and supervision of the state registrar shall perform all duties required of them by this [~~chapter~~] part and department rules.

(4) The state registrar appointed under Subsection (2)(e) shall, with the input of Utah stakeholders and the Uniform Law Commission, study the following items for the state's implementation of the compact:

(a) the feasibility of using systems developed by the National Association for Public Health Statistics and Information Systems, including the State and Territorial Exchange of Vital Events (STEVE) system and the Electronic Verification of Vital Events (EVVE) system,

or similar systems, to exchange putative father registry information with states that are parties to the compact;

(b) procedures necessary to share putative father information, located in the confidential registry maintained by the state registrar, upon request from the state registrar of another state that is a party to the compact;

(c) procedures necessary for the state registrar to access putative father information located in a state that is a party to the compact, and share that information with persons who request a certificate from the state registrar;

(d) procedures necessary to ensure that the name of the mother of the child who is the subject of a putative father's notice of commencement, filed pursuant to Section 78B-6-121, is kept confidential when a state that is a party to the compact accesses this state's confidential registry through the state registrar; and

(e) procedures necessary to ensure that a putative father's registration with a state that is a party to the compact is given the same effect as a putative father's notice of commencement filed pursuant to Section 78B-6-121.

Section 179. Section **26B-8-103**, which is renumbered from Section 26-2-4 is renumbered and amended to read:

[~~26-2-4~~]. 26B-8-103. Content and form of certificates and reports.

(1) As used in this section:

(a) "Additional information" means information that is beyond the information necessary to comply with federal standards or state law for registering a birth.

(b) "Diacritical mark" means a mark on a letter from the ISO basic Latin alphabet used to indicate a special pronunciation.

(c) "Diacritical mark" includes accents, tildes, graves, umlauts, and cedillas.

(2) Except as provided in Subsection (8), to promote and maintain nationwide uniformity in the vital records system, the forms of certificates, certification, reports, and other documents and records required by this [~~chapter~~] part or the rules implementing this [~~chapter~~] part shall include as a minimum the items recommended by the federal agency responsible for national vital statistics, subject to approval, additions, and modifications by the department.

(3) Certificates, certifications, forms, reports, other documents and records, and the form of communications between persons required by this [~~chapter~~] part shall be prepared in

the format prescribed by department rule.

(4) All vital records shall include the date of filing.

(5) Certificates, certifications, forms, reports, other documents and records, and communications between persons required by this [~~chapter~~] part may be signed, filed, verified, registered, and stored by photographic, electronic, or other means as prescribed by department rule.

(6) (a) An individual may use a diacritical mark in an application for a vital record.

(b) The office shall record a diacritical mark on a vital record as indicated on the application for the vital record.

(7) The absence of a diacritical mark on a vital record does not render the document invalid or affect any constructive notice imparted by proper recordation of the document.

(8) (a) The state:

(i) may collect the Social Security number of a deceased individual; and

(ii) may not include the Social Security number of an individual on a certificate of death.

(b) For registering a birth, the department may not require an individual to provide additional information.

(c) The department may request additional information if the department provides a written statement that:

(i) discloses that providing the additional information is voluntary;

(ii) discloses how the additional information will be used and the duration of use;

(iii) describes how the department prevents the additional information from being used in a manner different from the disclosure given under Subsection (6)(c)(ii); and

(iv) includes a notice that the individual is consenting to the department's use of the additional information by providing the additional information.

(d) (i) Beginning July 1, 2022, an individual may submit a written request to the department to de-identify the individual's additional information contained in the department's databases.

(ii) Upon receiving the written request, the department shall de-identify the additional information.

(e) The department shall de-identify additional information contained in the

department's databases before the additional information is held by the department for longer than six years.

Section 180. Section **26B-8-104**, which is renumbered from Section 26-2-5 is renumbered and amended to read:

[~~26-2-5~~]. 26B-8-104. Birth certificates -- Execution and registration requirements.

(1) As used in this section, "birthing facility" means a general acute hospital or birthing center as defined in Section [~~26-21-2~~] 26B-2-201.

(2) For each live birth occurring in the state, a certificate shall be filed with the local registrar for the district in which the birth occurred within 10 days following the birth. The certificate shall be registered if it is completed and filed in accordance with this [~~chapter~~] part.

(3) (a) For each live birth that occurs in a birthing facility, the administrator of the birthing facility, or his designee, shall obtain and enter the information required under this [~~chapter~~] part on the certificate, securing the required signatures, and filing the certificate.

(b) (i) The date, time, place of birth, and required medical information shall be certified by the birthing facility administrator or his designee.

(ii) The attending physician or nurse midwife may sign the certificate, but if the attending physician or nurse midwife has not signed the certificate within seven days of the date of birth, the birthing facility administrator or his designee shall enter the attending physician's or nurse midwife's name and transmit the certificate to the local registrar.

(iii) The information on the certificate about the parents shall be provided and certified by the mother or father or, in their incapacity or absence, by a person with knowledge of the facts.

(4) (a) For live births that occur outside a birthing facility, the birth certificate shall be completed and filed by the physician, physician assistant, nurse, midwife, or other person primarily responsible for providing assistance to the mother at the birth. If there is no such person, either the presumed or declarant father shall complete and file the certificate. In his absence, the mother shall complete and file the certificate, and in the event of her death or disability, the owner or operator of the premises where the birth occurred shall do so.

(b) The certificate shall be completed as fully as possible and shall include the date, time, and place of birth, the mother's name, and the signature of the person completing the

certificate.

(5) (a) For each live birth to an unmarried mother that occurs in a birthing facility, the administrator or director of that facility, or his designee, shall:

(i) provide the birth mother and declarant father, if present, with:

(A) a voluntary declaration of paternity form published by the state registrar;

(B) oral and written notice to the birth mother and declarant father of the alternatives to, the legal consequences of, and the rights and responsibilities that arise from signing the declaration; and

(C) the opportunity to sign the declaration;

(ii) witness the signature of a birth mother or declarant father in accordance with Section 78B-15-302 if the signature occurs at the facility;

(iii) enter the declarant father's information on the original birth certificate, but only if the mother and declarant father have signed a voluntary declaration of paternity or a court or administrative agency has issued an adjudication of paternity; and

(iv) file the completed declaration with the original birth certificate.

(b) If there is a presumed father, the voluntary declaration will only be valid if the presumed father also signs the voluntary declaration.

(c) The state registrar shall file the information provided on the voluntary declaration of paternity form with the original birth certificate and may provide certified copies of the declaration of paternity as otherwise provided under Title 78B, Chapter 15, Utah Uniform Parentage Act.

(6) (a) The state registrar shall publish a form for the voluntary declaration of paternity, a description of the process for filing a voluntary declaration of paternity, and of the rights and responsibilities established or effected by that filing, in accordance with Title 78B, Chapter 15, Utah Uniform Parentage Act.

(b) Information regarding the form and services related to voluntary paternity establishment shall be made available to birthing facilities and to any other entity or individual upon request.

(7) The name of a declarant father may only be included on the birth certificate of a child of unmarried parents if:

(a) the mother and declarant father have signed a voluntary declaration of paternity; or

(b) a court or administrative agency has issued an adjudication of paternity.

(8) Voluntary declarations of paternity, adjudications of paternity by judicial or administrative agencies, and voluntary rescissions of paternity shall be filed with and maintained by the state registrar for the purpose of comparing information with the state case registry maintained by the Office of Recovery Services pursuant to Section 62A-11-104.

Section 181. Section **26B-8-105**, which is renumbered from Section 26-2-5.5 is renumbered and amended to read:

[~~26-2-5.5~~]. 26B-8-105. Requirement to obtain parents' social security numbers.

(1) For each live birth that occurs in this state, the administrator of the birthing facility, as defined in Section [~~26-2-5~~] 26B-8-104, or other person responsible for completing and filing the birth certificate under Section [~~26-2-5~~] 26B-8-104 shall obtain the social security numbers of each parent and provide those numbers to the state registrar.

(2) Each parent shall furnish his or her social security number to the person authorized to obtain the numbers under Subsection (1) unless a court or administrative agency has determined there is good cause for not furnishing a number under Subsection (1).

(3) The state registrar shall, as soon as practicable, supply those social security numbers to the Office of Recovery Services within the Department of Human Services.

(4) The social security numbers obtained under this section may not be recorded on the child's birth certificate.

(5) The state may not use any social security number obtained under this section for any reason other than enforcement of child support orders in accordance with the federal Family Support Act of 1988, [~~Public Law~~] Pub. L. No. 100-485.

Section 182. Section **26B-8-106**, which is renumbered from Section 26-2-6 is renumbered and amended to read:

[~~26-2-6~~]. 26B-8-106. Foundling certificates.

(1) A foundling certificate shall be filed for each infant of unknown parentage found in the state. The certificate shall be prepared and filed with the local registrar of the district in which the infant was found by the person assuming custody.

(2) The certificate shall be filed within 10 days after the infant is found and is acceptable for all purposes in lieu of a certificate of birth.

Section 183. Section **26B-8-107**, which is renumbered from Section 26-2-7 is

renumbered and amended to read:

[~~26-2-7~~]. 26B-8-107. Correction of errors or omissions in vital records -- Conflicting birth and foundling certificates -- Rulemaking.

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules:

(1) governing applications to correct alleged errors or omissions on any vital record;

(2) establishing procedures to resolve conflicting birth and foundling certificates; and

(3) allowing for the correction and reissuance of a vital record that was originally created omitting a diacritical mark.

Section 184. Section **26B-8-108**, which is renumbered from Section 26-2-8 is renumbered and amended to read:

[~~26-2-8~~]. 26B-8-108. Birth certificates -- Delayed registration.

(1) When a certificate of birth of a person born in this state has not been filed within the time provided in Subsection [~~26-2-5~~] 26B-8-104(2), a certificate of birth may be filed in accordance with department rules and subject to this section.

(2) (a) The registrar shall mark a certificate of birth as "delayed" and show the date of registration if the certificate is registered one year or more after the date of birth.

(b) The registrar shall abstract a summary statement of the evidence submitted in support of delayed registration onto the certificate.

(3) When the minimum evidence required for delayed registration is not submitted or when the state registrar has reasonable cause to question the validity or adequacy of the evidence supporting the application, and the deficiencies are not corrected, the state registrar:

(a) may not register the certificate; and

(b) shall provide the applicant with a written statement indicating the reasons for denial of registration.

(4) The state registrar has no duty to take further action regarding an application which is not actively pursued.

Section 185. Section **26B-8-109**, which is renumbered from Section 26-2-9 is renumbered and amended to read:

[~~26-2-9~~]. 26B-8-109. Birth certificates -- Petition for issuance of delayed certificate -- Court procedure.

(1) (a) If registration of a certificate of birth under Section [~~26-2-8~~] 26B-8-108 is denied, the person seeking registration may bring an action by a verified petition in the Utah [~~district~~] court encompassing where the petitioner resides or in the district encompassing Salt Lake City.

(b) The petition shall request an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered.

(2) The petition shall be on a form furnished by the state registrar and shall allege:

(a) the person for whom registration of a delayed certificate is sought was born in this state and is still living;

(b) no registered certificate of birth of the person can be found in the state office of vital statistics or the office of any local registrar;

(c) diligent efforts by the petitioner have failed to obtain the evidence required by department rule; and

(d) the state registrar has denied the petitioner's request to register a delayed certificate of birth.

(3) The petition shall be accompanied by a written statement of the state registrar indicating the reasons for denial of registration and all documentary evidence which was submitted in support of registration.

(4) The court shall fix a time and place for hearing the petition and shall give the state registrar 15 days notice of the hearing. The state registrar or his authorized representative may appear and testify at the hearing.

(5) (a) If the court finds the person for whom registration of a certificate of birth is sought under Section 26-2-8 was born in this state, it shall make findings as to the place and date of birth, parentage, and other findings as may be required and shall issue an order, on a form prescribed and furnished by the state registrar, to establish a court-ordered delayed certificate of birth.

(b) The order shall include the birth data to be registered, a description of the evidence presented, and the date of the court's action.

[~~(b)~~] (c) The clerk of the court shall forward each order to the state registrar not later than the tenth day of the calendar month following the month in which the order was entered.

(d) The order described in Subsection (5)(a) shall be registered by the state registrar

and constitutes the certificate of birth.

Section 186. Section **26B-8-110**, which is renumbered from Section 26-2-10 is renumbered and amended to read:

[~~26-2-10~~]. 26B-8-110. Supplementary certificate of birth.

(1) An individual born in this state may request the state registrar to register a supplementary birth certificate for the individual if:

(a) the individual is legally recognized as a child of the individual's natural parents when the individual's natural parents are subsequently married;

(b) the individual's parentage has been determined by a state court of the United States or a Canadian provincial court with jurisdiction; or

(c) the individual has been legally adopted, as a child or as an adult, under the law of this state, any other state, or any province of Canada.

(2) The application for registration of a supplementary birth certificate may be made by:

(a) the individual requesting registration under Subsection (1) if the individual is of legal age;

(b) a legal representative; or

(c) any agency authorized to receive children for placement or adoption under the laws of this or any other state.

(3) (a) The state registrar shall require that an applicant submit identification and proof according to department rules.

(b) In the case of an adopted individual, that proof may be established by order of the court in which the adoption proceedings were held.

(4) (a) After the supplementary birth certificate is registered, any information disclosed from the record shall be from the supplementary birth certificate.

(b) Access to the original birth certificate and to the evidence submitted in support of the supplementary birth certificate are not open to inspection except upon the order of a Utah district court or as described in Section 78B-6-141 or Section 78B-6-144.

Section 187. Section **26B-8-111**, which is renumbered from Section 26-2-11 is renumbered and amended to read:

[~~26-2-11~~]. 26B-8-111. Name or sex change -- Registration of court order and

amendment of birth certificate.

(1) When a person born in this state has a name change or sex change approved by an order of a Utah [~~district~~] court or a court of competent jurisdiction of another state or a province of Canada, a certified copy of the order may be filed with the state registrar with an application form provided by the registrar.

(2) (a) Upon receipt of the application, a certified copy of the order, and payment of the required fee, the state registrar shall review the application, and if complete, register it and note the fact of the amendment on the otherwise unaltered original certificate.

(b) The amendment shall be registered with and become a part of the original certificate and a certified copy shall be issued to the applicant without additional cost.

Section 188. Section **26B-8-112**, which is renumbered from Section 26-2-12.5 is renumbered and amended to read:

[~~26-2-12.5~~]. 26B-8-112. Certified copies of birth certificates -- Fees credited to Children's Account.

(1) In addition to the fees provided for in Section 26B-1-209, the department and local registrars authorized to issue certified copies shall charge an additional $3 fee for each certified copy of a birth certificate, including certified copies of supplementary and amended birth certificates, under Sections [~~26-2-8 through 26-2-11~~] 26B-8-108 through 26B-8-111. [~~This~~]

(2) The additional fee described in Subsection (1) may be charged only for the first copy requested at any one time.

[~~(2)~~] (3) The fee shall be transmitted monthly to the state treasurer and credited to the Children's Account [~~established~~] created in Section 80-2-501.

Section 189. Section **26B-8-113**, which is renumbered from Section 26-2-12.6 is renumbered and amended to read:

[~~26-2-12.6~~]. 26B-8-113. Fee waived for certified copy of birth certificate.

(1) Notwithstanding [~~Section~~] Sections 26B-1-209 and [~~Section 26-2-12.5~~] 26B-6-112, the department shall waive a fee that would otherwise be charged for a certified copy of a birth certificate, if the individual whose birth is confirmed by the birth certificate is:

(a) the individual requesting the certified copy of the birth certificate; and

(b) (i) homeless, as defined in Section [~~26-18-411~~] 26B-X-XXX;

(ii) a person who is homeless, as defined in Section 35A-5-302;

(iii) an individual whose primary nighttime residence is a location that is not designed for or ordinarily used as a sleeping accommodation for an individual;

(iv) a homeless service provider as verified by the Department of Workforce Services; or

(v) a homeless child or youth, as defined in 42 U.S.C. Sec. 11434a.

(2) To satisfy the requirement in Subsection (1)(b), the department shall accept written verification that the individual is homeless or a person, child, or youth who is homeless from:

(a) a homeless shelter;

(b) a permanent housing, permanent, supportive, or transitional facility, as defined in Section 35A-5-302;

(c) the Department of Workforce Services;

(d) a homeless service provider as verified by the Department of Workforce Services; or

(e) a local educational agency liaison for homeless children and youth designated under 42 U.S.C. Sec. 11432(g)(1)(J)(ii).

[~~(3) Before October 1, 2022, the office shall submit a report to the Health and Human Services Interim Committee providing several options on how the office can eliminate or significantly reduce birth certificate fees.~~]

Section 190. Section **26B-8-114**, which is renumbered from Section 26-2-13 is renumbered and amended to read:

[~~26-2-13~~]. 26B-8-114. Certificate of death -- Execution and registration requirements -- Information provided to lieutenant governor.

(1) (a) A certificate of death for each death that occurs in this state shall be filed with the local registrar of the district in which the death occurs, or as otherwise directed by the state registrar, within five days after death and prior to the decedent's interment, any other disposal, or removal from the registration district where the death occurred.

(b) A certificate of death shall be registered if the certificate of death is completed and filed in accordance with this [~~chapter~~] part.

(2) (a) If the place of death is unknown but the dead body is found in this state:

(i) the certificate of death shall be completed and filed in accordance with this section; and

(ii) the place where the dead body is found shall be shown as the place of death.

(b) If the date of death is unknown, the date shall be determined by approximation.

(3) (a) When death occurs in a moving conveyance in the United States and the decedent is first removed from the conveyance in this state:

(i) the certificate of death shall be filed with:

(A) the local registrar of the district where the decedent is removed; or

(B) a person designated by the state registrar; and

(ii) the place where the decedent is removed shall be considered the place of death.

(b) When a death occurs on a moving conveyance outside the United States and the decedent is first removed from the conveyance in this state:

(i) the certificate of death shall be filed with:

(A) the local registrar of the district where the decedent is removed; or

(B) a person designated by the state registrar; and

(ii) the certificate of death shall show the actual place of death to the extent it can be determined.

(4) (a) Subject to Subsections (4)(d) and (10), a custodial funeral service director or, if a funeral service director is not retained, a dispositioner shall sign the certificate of death.

(b) The custodial funeral service director, an agent of the custodial funeral service director, or, if a funeral service director is not retained, a dispositioner shall:

(i) file the certificate of death prior to any disposition of a dead body or fetus; and

(ii) obtain the decedent's personal data from the next of kin or the best qualified person or source available, including the decedent's social security number, if known.

(c) The certificate of death may not include the decedent's social security number.

(d) A dispositioner may not sign a certificate of death, unless the signature is witnessed by the state registrar or a local registrar.

(5) (a) Except as provided in Section [~~26-2-14~~] 26B-8-103, fetal death certificates, the medical section of the certificate of death shall be completed, signed, and returned to the funeral service director, or, if a funeral service director is not retained, a dispositioner, within 72 hours after death by the health care professional who was in charge of the decedent's care for the illness or condition which resulted in death, except when inquiry is required by [~~Title 26, Chapter 4, Utah Medical Examiner Act~~] Chapter X, Part X, Utah Medical Examiner.

(b) In the absence of the health care professional or with the health care professional's approval, the certificate of death may be completed and signed by an associate physician, the chief medical officer of the institution in which death occurred, or a physician who performed an autopsy upon the decedent, if:

(i) the person has access to the medical history of the case;

(ii) the person views the decedent at or after death; and

(iii) the death is not due to causes required to be investigated by the medical examiner.

(6) When death occurs more than 365 days after the day on which the decedent was last treated by a health care professional, the case shall be referred to the medical examiner for investigation to determine and certify the cause, date, and place of death.

(7) When inquiry is required by [~~Title 26, Chapter 4, Utah Medical Examiner Act~~] Chapter X, Part X, Utah Medical Examiner, the medical examiner shall make an investigation and complete and sign the medical section of the certificate of death within 72 hours after taking charge of the case.

(8) If the cause of death cannot be determined within 72 hours after death:

(a) the medical section of the certificate of death shall be completed as provided by department rule;

(b) the attending health care professional or medical examiner shall give the funeral service director, or, if a funeral service director is not retained, a dispositioner, notice of the reason for the delay; and

(c) final disposition of the decedent may not be made until authorized by the attending health care professional or medical examiner.

(9) (a) When a death is presumed to have occurred within this state but the dead body cannot be located, a certificate of death may be prepared by the state registrar upon receipt of an order of a Utah [~~district~~] court.

(b) The order described in Subsection (9)(a) shall include a finding of fact stating the name of the decedent, the date of death, and the place of death.

(c) A certificate of death prepared under Subsection (9)(a) shall:

(i) show the date of registration; and

(ii) identify the court and the date of the order.

(10) It is unlawful for a dispositioner to charge for or accept any remuneration for:

(a) signing a certificate of death; or

(b) performing any other duty of a dispositioner, as described in this section.

(11) The state registrar shall, within five business days after the day on which the state registrar or local registrar registers a certificate of death for a Utah resident, inform the lieutenant governor of:

(a) the decedent's name, last known residential address, date of birth, and date of death; and

(b) any other information requested by the lieutenant governor to assist the county clerk in identifying the decedent for the purpose of removing the decedent from the official register of voters.

(12) The lieutenant governor shall, within one business day after the day on which the lieutenant governor receives the information described in Subsection (11), provide the information to the county clerks.

Section 191. Section **26B-8-115**, which is renumbered from Section 26-2-14 is renumbered and amended to read:

[~~26-2-14~~]. 26B-8-115. Fetal death certificate -- Filing and registration requirements.

(1) A fetal death certificate shall be filed for each fetal death which occurs in this state. The certificate shall be filed within five days after delivery with the local registrar or as otherwise directed by the state registrar. The certificate shall be registered if it is completed and filed in accordance with this [~~chapter~~] part.

(2) When a dead fetus is delivered in an institution, the institution administrator or his designated representative shall prepare and file the fetal death certificate. The attending physician shall state in the certificate the cause of death and sign the certificate.

(3) When a dead fetus is delivered outside an institution, the physician in attendance at or immediately after delivery shall complete, sign, and file the fetal death certificate.

(4) When a fetal death occurs without medical attendance at or immediately after the delivery or when inquiry is required by [~~Title 26, Chapter 4, Utah Medical Examiner Act~~] Chapter X, Part X, Utah Medical Examiner, the medical examiner shall investigate the cause of death and prepare and file the certificate of fetal death within five days after taking charge of the case.

(5) When a fetal death occurs in a moving conveyance and the dead fetus is first removed from the conveyance in this state or when a dead fetus is found in this state and the place of death is unknown, the death shall be registered in this state. The place where the dead fetus was first removed from the conveyance or found shall be considered the place of death.

(6) Final disposition of the dead fetus may not be made until the fetal death certificate has been registered.

Section 192. Section **26B-8-116**, which is renumbered from Section 26-2-14.1 is renumbered and amended to read:

[~~26-2-14.1~~]. 26B-8-116. Certificate of birth resulting in stillbirth.

(1) [~~For purposes of this section and Section 26-2-14.2~~] As used in this section, "stillbirth" and "stillborn child" [~~shall have the same meaning~~] mean the same as "dead fetus" as defined in Section [~~26-2-2~~] 26B-8-101.

(2) (a) In addition to the requirements of Section [~~26-2-14~~] 26B-8-115, the state registrar shall establish a certificate of birth resulting in stillbirth on a form approved by the state registrar for each stillbirth occurring in this state.

(b) This certificate shall be offered to the parent or parents of a stillborn child.

(3) The certificate of birth resulting in stillbirth shall meet all of the format and filing requirements of Sections 26-2-4 and 26-2-5, relating to a live birth.

(4) The person who prepares a certificate pursuant to this section shall leave blank any references to the stillborn child's name if the stillborn child's parent or parents do not wish to provide a name for the stillborn child.

(5) Notwithstanding Subsections (2) and (3), the certificate of birth resulting in stillbirth shall be filed with the designated registrar within 10 days following the delivery and prior to cremation or removal of the fetus from the registration district.

Section 193. Section **26B-8-117**, which is renumbered from Section 26-2-14.2 is renumbered and amended to read:

[~~26-2-14.2~~]. 26B-8-117. Delayed registration of birth resulting in stillbirth.

When a birth resulting in stillbirth occurring in this state has not been registered within one year after the date of delivery, a certificate marked "delayed" may be filed and registered in accordance with department rule relating to evidentiary and other requirements sufficient to substantiate the alleged facts of birth resulting in stillbirth.

Section 194. Section **26B-8-118**, which is renumbered from Section 26-2-14.3 is renumbered and amended to read:

[~~26-2-14.3~~]. 26B-8-118. Certificate of early term stillbirth.

(1) As used in this section, "early term stillborn child" means a product of human conception, other than in the circumstances described in Subsection 76-7-301(1), that:

(a) is of at least 16 weeks' gestation but less than 20 weeks' gestation, calculated from the day on which the mother's last normal menstrual period began to the day of delivery; and

(b) is not born alive.

(2) The state registrar shall issue a certificate of early term stillbirth to a parent of an early term stillborn child if:

(a) the parent requests, on a form created by the state registrar, that the state registrar register and issue a certificate of early term stillbirth for the early term stillborn child; and

(b) the parent files with the state registrar:

(i) (A) a signed statement from a physician confirming the delivery of the early term stillborn child; or

(B) an accurate copy of the parent's medical records related to the early term stillborn child; and

(ii) any other record the state registrar determines, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, is necessary for accurate recordkeeping.

(3) The certificate of early term stillbirth described in Subsection (2) shall meet all of the format and filing requirements of Section [~~26-2-4~~] 26B-8-103.

(4) A person who prepares a certificate of early term stillbirth under this section shall leave blank any references to an early term stillborn child's name if the early term stillborn child's parent does not wish to provide a name for the early term stillborn child.

Section 195. Section **26B-8-119**, which is renumbered from Section 26-2-15 is renumbered and amended to read:

[~~26-2-15~~]. 26B-8-119. Petition for establishment of unregistered birth or death -- Court procedure.

(1) A person holding a direct, tangible, and legitimate interest as described in Subsection [~~26-2-22~~] 26B-8-126(3)(a) or (b) may petition for a court order establishing the

fact, time, and place of a birth or death that is not registered or for which a certified copy of the registered birth or death certificate is not obtainable. The person shall verify the petition and file the petition in the Utah [~~district~~] court for the county where:

(a) the birth or death is alleged to have occurred;

(b) the person resides whose birth is to be established; or

(c) the decedent named in the petition resided at the date of death.

(2) In order for the court to have jurisdiction, the petition shall:

(a) allege the date, time, and place of the birth or death; and

(b) state either that no certificate of birth or death has been registered or that a copy of the registered certificate cannot be obtained.

(3) The court shall set a hearing for five to 10 days after the day on which the petition is filed.

(4) (a) If the time and place of birth or death are in question, the court shall hear available evidence and determine the time and place of the birth or death.

(b) If the time and place of birth or death are not in question, the court shall determine the time and place of birth or death to be those alleged in the petition.

(5) A court order under this section shall be made on a form prescribed and furnished by the department and is effective upon the filing of a certified copy of the order with the state registrar.

(6) (a) For purposes of this section, the birth certificate of an adopted alien child, as defined in Section 78B-6-108, is considered to be unobtainable if the child was born in a country that is not recognized by department rule as having an established vital records registration system.

(b) If the adopted child was born in a country recognized by department rule, but a person described in Subsection (1) is unable to obtain a certified copy of the birth certificate, the state registrar shall authorize the preparation of a birth certificate if the state registrar receives a written statement signed by the registrar of the child's birth country stating a certified copy of the birth certificate is not available.

Section 196. Section **26B-8-120**, which is renumbered from Section 26-2-16 is renumbered and amended to read:

[~~26-2-16~~]. 26B-8-120. Certificate of death -- Duties of a custodial funeral

service director, an agent of a funeral service director, or a dispositioner -- Medical certification -- Records of funeral service director or dispositioner -- Information filed with local registrar -- Unlawful signing of certificate of death.

(1) The custodial funeral service director or, if a funeral service director is not retained, a dispositioner shall sign the certificate of death prior to any disposition of a dead body or dead fetus.

(2) The custodial funeral service director, an agent of the custodial funeral service director, or, if a funeral service director is not retained, a dispositioner shall:

(a) obtain personal and statistical information regarding the decedent from the available persons best qualified to provide the information;

(b) present the certificate of death to the attending health care professional, if any, or to the medical examiner who shall certify the cause of death and other information required on the certificate of death;

(c) provide the address of the custodial funeral service director or, if a funeral service director is not retained, a dispositioner;

(d) certify the date and place of burial; and

(e) file the certificate of death with the state or local registrar.

(3) A funeral service director, dispositioner, embalmer, or other person who removes a dead body or dead fetus from the place of death or transports or is in charge of final disposal of a dead body or dead fetus, shall keep a record identifying the dead body or dead fetus, and containing information pertaining to receipt, removal, and delivery of the dead body or dead fetus as prescribed by department rule.

(4) (a) Not later than the tenth day of each month, every licensed funeral service establishment shall send to the local registrar and the department a list of the information required in Subsection (3) for each casket furnished and for funerals performed when no casket was furnished, during the preceding month.

(b) The list described in Subsection (4)(a) shall be in the form prescribed by the state registrar.

(5) Any person who intentionally signs the portion of a certificate of death that is required to be signed by a funeral service director or a dispositioner under Subsection (1) is guilty of a class B misdemeanor, unless the person:

(a) (i) is a funeral service director; and

(ii) is employed by a licensed funeral establishment; or

(b) is a dispositioner, if a funeral service director is not retained.

(6) The state registrar shall post information on the state registrar's website, providing instructions to a dispositioner for complying with the requirements of law relating to the dispositioner's responsibilities for:

(a) completing and filing a certificate of death; and

(b) possessing, transporting, and disposing of a dead body or dead fetus.

(7) The provisions of this [~~chapter~~] part shall be construed to avoid interference, to the fullest extent possible, with the ceremonies, customs, rites, or beliefs of the decedent and the decedent's next of kin for disposing of a dead body or dead fetus.

Section 197. Section **26B-8-121**, which is renumbered from Section 26-2-17 is renumbered and amended to read:

[~~26-2-17~~]. 26B-8-121. Certificate of death -- Registration prerequisite to interment -- Burial-transit permits -- Procedure where body donated under anatomical gift law -- Permit for disinterment.

(1) (a) A dead body or dead fetus may not be interred or otherwise disposed of or removed from the registration district in which death or fetal death occurred or the remains are found until a certificate of death is registered.

(b) Subsection (1)(a) does not apply to fetal remains for a fetus that is less than 20 weeks in gestational age.

(2) (a) For deaths or fetal deaths which occur in this state, no burial-transit permit is required for final disposition of the remains if:

(i) disposition occurs in the state and is performed by a funeral service director; or

(ii) the disposition takes place with authorization of the next of kin and in:

(A) a general acute hospital as [~~that term is~~] defined in Section [~~26-21-2~~] 26B-2-201, that is licensed by the department; or

(B) in a pathology laboratory operated under contract with a general acute hospital licensed by the department.

(b) For an abortion or miscarriage that occurs at a health care facility, no burial-transit permit is required for final disposition of the fetal remains if:

(i) disposition occurs in the state and is performed by a funeral service director; or

(ii) the disposition takes place:

(A) with authorization of the parent of a miscarried fetus or the pregnant woman for an aborted fetus; and

(B) in a general acute hospital as [~~that term is~~] defined in Section [~~26-21-2~~] 26B-2-201, or a pathology laboratory operated under contract with a general acute hospital.

(3) (a) A burial-transit permit shall be issued by the local registrar of the district where the certificate of death or fetal death is registered:

(i) for a dead body or a dead fetus to be transported out of the state for final disposition; or

(ii) when disposition of the dead body or dead fetus is made by a person other than a funeral service director.

(b) For fetal remains that are less than 20 weeks in gestational age, a burial-transit permit shall be issued by the local registrar of the district where the health care facility that is in possession of the fetal remains is located:

(i) for the fetal remains to be transported out of the state for final disposition; or

(ii) when disposition of the fetal remains is made by a person other than a funeral service director.

(c) A local registrar issuing a burial-transit permit issued under Subsection (3)(b):

(i) may not require an individual to designate a name for the fetal remains; and

(ii) may leave the space for a name on the burial-transit permit blank; and

(d) shall redact from any public records maintained under this [~~chapter~~] part any information:

(i) that is submitted under Subsection (3)(c); and

(ii) that may be used to identify the parent or pregnant woman.

(4) A burial-transit permit issued under the law of another state which accompanies a dead body, dead fetus, or fetal remains brought into this state is authority for final disposition of the dead body, dead fetus, or fetal remains in this state.

(5) When a dead body or dead fetus or any part of the dead body or dead fetus has been donated under [~~the~~] Chapter X, Part X, Revised Uniform Anatomical Gift Act, or similar laws of another state and the preservation of the gift requires the immediate transportation of the

dead body, dead fetus, or any part of the body or fetus outside of the registration district in which death occurs or the remains are found, or into this state from another state, the dead body or dead fetus or any part of the body or fetus may be transported and the burial-transit permit required by this section obtained within a reasonable time after transportation.

(6) A permit for disinterment and reinterment is required prior to disinterment of a dead body, dead fetus, or fetal remains, except as otherwise provided by statute or department rule.

Section 198. Section **26B-8-122**, which is renumbered from Section 26-2-18 is renumbered and amended to read:

[~~26-2-18~~]. 26B-8-122. Interments -- Duties of sexton or person in charge -- Record of interments -- Information filed with local registrar.

(1) (a) A sexton or person in charge of any premises in which interments are made may not inter or permit the interment of any dead body, dead fetus, or fetal remains unless the interment is made by a funeral service director or by a person holding a burial-transit permit.

(b) The right and duty to control the disposition of a deceased person shall be governed by Sections 58-9-601 through 58-9-604.

(2) (a) The sexton or the person in charge of any premises where interments are made shall keep a record of all interments made in the premises under their charge, stating the name of the decedent, place of death, date of burial, and name and address of the funeral service director or other person making the interment.

(b) The record described in this Subsection (2) shall be open to public inspection.

(c) A city or county clerk may, at the clerk's option, maintain the interment records described in this Subsection (2) on behalf of the sexton or person in charge of any premises in which interments are made.

(3) (a) Not later than the tenth day of each month, the sexton, person in charge of the premises, or city or county clerk who maintains the interment records shall send to the local registrar and the department a list of all interments made in the premises during the preceding month.

(b) The list described in Subsection (3)(a) shall be in the form prescribed by the state registrar.

Section 199. Section **26B-8-123**, which is renumbered from Section 26-2-19 is

renumbered and amended to read:

[~~26-2-19~~]. 26B-8-123. Rules of department for transmittal of certificates and keeping of records by local registrar.

Each local registrar shall transmit all records registered by him to the department in accordance with department rules. The manner of keeping local copies of vital records and the uses of them shall be prescribed by department rules.

Section 200. Section **26B-8-124**, which is renumbered from Section 26-2-21 is renumbered and amended to read:

[~~26-2-21~~]. 26B-8-124. Local registrars authorized to issue certified copies of records.

The state registrar may authorize local registrars to issue certified copies of vital records.

Section 201. Section **26B-8-125**, which is renumbered from Section 26-2-22 is renumbered and amended to read:

[~~26-2-22~~]. 26B-8-125. Inspection of vital records.

(1) As used in this section:

(a) "Designated legal representative" means an attorney, physician, funeral service director, genealogist, or other agent of the subject, or an immediate family member of the subject, who has been delegated the authority to access vital records.

(b) "Drug use intervention or suicide prevention effort" means a program that studies or promotes the prevention of drug overdose deaths or suicides in the state.

(c) "Immediate family member" means a spouse, child, parent, sibling, grandparent, or grandchild.

(2) (a) The vital records shall be open to inspection, but only in compliance with the provisions of this [~~chapter~~] part, department rules, and Sections 78B-6-141 and 78B-6-144.

(b) It is unlawful for any state or local officer or employee to disclose data contained in vital records contrary to this [~~chapter~~] part, department rule, Section 78B-6-141, or Section 78B-6-144.

(c) (i) An adoption document is open to inspection as provided in Section 78B-6-141 or Section 78B-6-144.

(ii) A birth parent may not access an adoption document under Subsection

78B-6-141(3).

(d) A custodian of vital records may permit inspection of a vital record or issue a certified copy of a record or a part of a record when the custodian is satisfied that the applicant has demonstrated a direct, tangible, and legitimate interest.

(3) Except as provided in Subsection (4), a direct, tangible, and legitimate interest in a vital record is present only if:

(a) the request is from:

(i) the subject;

(ii) an immediate family member of the subject;

(iii) the guardian of the subject;

(iv) a designated legal representative of the subject; or

(v) a person, including a child-placing agency as defined in Section 78B-6-103, with whom a child has been placed pending finalization of an adoption of the child;

(b) the request involves a personal or property right of the subject of the record;

(c) the request is for official purposes of a public health authority or a state, local, or federal governmental agency;

(d) the request is for a drug use intervention or suicide prevention effort or a statistical or medical research program and prior consent has been obtained from the state registrar; or

(e) the request is a certified copy of an order of a court of record specifying the record to be examined or copied.

(4) (a) Except as provided in Title 78B, Chapter 6, Part 1, Utah Adoption Act, a parent, or an immediate family member of a parent, who does not have legal or physical custody of or visitation or parent-time rights for a child because of the termination of parental rights under Title 80, Chapter 4, Termination and Restoration of Parental Rights, or by virtue of consenting to or relinquishing a child for adoption pursuant to Title 78B, Chapter 6, Part 1, Utah Adoption Act, may not be considered as having a direct, tangible, and legitimate interest under this section.

(b) Except as provided in Subsection (2)(d), a commercial firm or agency requesting names, addresses, or similar information may not be considered as having a direct, tangible, and legitimate interest under this section.

(5) Upon payment of a fee established in accordance with Section 63J-1-504, the office

shall make the following records available to the public:

(a) except as provided in Subsection [~~26-2-10~~] 26B-8-110(4)(b), a birth record, excluding confidential information collected for medical and health use, if 100 years or more have passed since the date of birth;

(b) a death record if 50 years or more have passed since the date of death; and

(c) a vital record not subject to Subsection (5)(a) or (b) if 75 years or more have passed since the date of the event upon which the record is based.

(6) Upon payment of a fee established in accordance with Section 63J-1-504, the office shall make an adoption document available as provided in Sections 78B-6-141 and 78B-6-144.

(7) The office shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, establishing procedures and the content of forms as follows:

(a) for the inspection of adoption documents under Subsection 78B-6-141(4);

(b) for a birth parent's election to permit identifying information about the birth parent to be made available, under Section 78B-6-141;

(c) for the release of information by the mutual-consent, voluntary adoption registry, under Section 78B-6-144;

(d) for collecting fees and donations under Section 78B-6-144.5; and

(e) for the review and approval of a request described in Subsection (3)(d).

Section 202. Section **26B-8-126**, which is renumbered from Section 26-2-23 is renumbered and amended to read:

[~~26-2-23~~]. 26B-8-126. Records required to be kept by health care institutions -- Information filed with local registrar and department.

(1) (a) All administrators or other persons in charge of hospitals, nursing homes, or other institutions, public or private, to which persons resort for treatment of diseases, confinements, or are committed by law, shall record all the personal and statistical information about patients of their institutions as required in certificates prescribed by this [~~chapter~~] part.

(b) The information described in Subsection (1)(a) shall:

(i) be recorded for collection at the time of admission of a patient;

(ii) be obtained from the patient, if possible; and

(iii) if the information cannot be obtained from the patient, the information shall be secured in as complete a manner as possible from other persons acquainted with the facts.

(2) (a) When a dead body or dead fetus is released or disposed of by an institution, the person in charge of the institution shall keep a record showing:

(i) the name of the deceased;

(ii) the date of death of the deceased;

(iii) the name and address of the person to whom the dead body or dead fetus is released; and

(iv) the date that the dead body or dead fetus is removed from the institution.

(b) If final disposal is by the institution, the date, place, manner of disposition, and the name of the person authorizing disposition shall be recorded by the person in charge of the institution.

(3) Not later than the tenth day of each month, the administrator of each institution shall cause to be sent to the local registrar and the department a list of all births, deaths, fetal deaths, and induced abortions occurring in the institution during the preceding month. The list shall be in the form prescribed by the state registrar.

(4) A person or institution who, in good faith, releases a dead body or dead fetus, under this section, to a funeral service director or a dispositioner is immune from civil liability connected, directly or indirectly, with release of the dead body or dead fetus.

Section 203. Section **26B-8-127**, which is renumbered from Section 26-2-24 is renumbered and amended to read:

[~~26-2-24~~]. 26B-8-127. Marriage licenses -- Execution and filing requirements.

(1) The state registrar shall supply county clerks with application forms for marriage licenses.

(2) Completed applications shall be transmitted by the clerks to the state registrar monthly.

(3) The personal identification information contained on each application for a marriage license filed with the county clerk shall be entered on a form supplied by the state registrar.

(4) The person performing the marriage shall furnish the date and place of marriage and his name and address.

(5) The form described in Subsection (1) shall be completed and certified by the county clerk before it is filed with the state registrar.

Section 204. Section **26B-8-128**, which is renumbered from Section 26-2-25 is renumbered and amended to read:

[~~26-2-25~~]. 26B-8-128. Divorce or adoption -- Duty of court clerk to file certificates or reports.

(1) For each adoption, annulment of adoption, divorce, and annulment of marriage ordered or decreed in this state, the clerk of the court shall prepare a divorce certificate or report of adoption on a form furnished by the state registrar.

(2) The petitioner shall provide the information necessary to prepare the certificate or report under Subsection (1).

(3) The clerk shall:

(a) prepare the certificate or report under Subsection (1); and

(b) complete the remaining entries for the certificate or report immediately after the decree or order becomes final.

(4) On or before the 15th day of each month, the clerk shall forward the divorce certificates and reports of adoption under Subsection (1) completed by the clerk during the preceding month to the state registrar.

(5) (a) A report of adoption under Subsection (1) may be provided to the attorney who is providing representation of a party to the adoption or the child-placing agency, as defined in Section 78B-6-103, that is placing the child.

(b) If a report of adoption is provided to the attorney or the child-placing agency, as defined in Section 78B-6-103, the attorney or the child-placing agency shall immediately provide the report of adoption to the state registrar.

Section 205. Section **26B-8-129**, which is renumbered from Section 26-2-26 is renumbered and amended to read:

[~~26-2-26~~]. 26B-8-129. Certified copies of vital records -- Preparation by state and local registrars -- Evidentiary value.

(1) The state registrar and local registrars authorized by the department under Section [~~26-2-21~~] 26B-8-125 may prepare typewritten, photographic, electronic, or other reproductions of vital records and certify their correctness.

(2) Certified copies of the vital record, or authorized reproductions of the original, issued by either the state registrar or a designated local registrar are prima facie evidence in all

courts of the state with like effect as the vital record.

Section 206. Section **26B-8-130**, which is renumbered from Section 26-2-27 is renumbered and amended to read:

[~~26-2-27~~]. 26B-8-130. Identifying birth certificates of missing persons -- Procedures.

(1) As used in this section:

(a) "Division" means the Criminal Investigations and Technical Services Division, Department of Public Safety, in Title 53, Chapter 10, Criminal Investigations and Technical Services Act.

(b) "Missing child" means a person younger than 18 years of age who is missing from the person's home environment or a temporary placement facility for any reason, and whose whereabouts cannot be determined by the person responsible for the child's care.

(c) "Missing person" means a person who:

(i) is missing from the person's home environment; and

(ii) (A) has a physical or mental disability;

(B) is missing under circumstances that indicate that the person is endangered, missing involuntarily, or a victim of a catastrophe; or

(C) is a missing child.

(2) (a) In accordance with Section 53-10-203, upon the state registrar's notification by the division that a person who was born in this state is missing, the state and local registrars shall flag the registered birth certificate of that person so that when a copy of the registered birth certificate or information regarding the birth record is requested, the state and local registrars are alerted to the fact the registered birth certificate is that of a missing person.

(b) Upon notification by the division the missing person has been recovered, the state and local registrars shall remove the flag from that person's registered birth certificate.

(3) The state and local registrars may not provide a copy of a registered birth certificate of any person whose record is flagged under Subsection (2), except as approved by the division.

(4) (a) When a copy of the registered birth certificate of a person whose record has been flagged is requested in person, the state or local registrar shall require that person to complete a form supplying that person's name, address, telephone number, and relationship to

the missing person, and the name and birth date of the missing person.

(b) The state or local registrar shall inform the requester that a copy of the registered birth certificate will be mailed to the requester.

(c) The state or local registrar shall note the physical description of the person making the request, and shall immediately notify the division of the request and the information obtained pursuant to this Subsection (4).

(5) When a copy of the registered birth certificate of a person whose record has been flagged is requested in writing, the state or local registrar or personnel of the state or local registrar shall immediately notify the division, and provide it with a copy of the written request.

Section 207. Section **26B-8-131**, which is renumbered from Section 26-2-28 is renumbered and amended to read:

[~~26-2-28~~]. 26B-8-131. Birth certificate for foreign adoptees.

Upon presentation of a court order of adoption and an order establishing the fact, time, and place of birth under Section [~~26-2-15~~] 26B-6-119, the department shall prepare a birth certificate for an individual who:

(1) was adopted under the laws of this state; and

(2) was at the time of adoption, as a child or as an adult, considered an alien child or adult for whom the court received documentary evidence of lawful admission under Section 78B-6-108.

Section 208. Section **26B-8-132**, which is renumbered from Section 26-34-4 is renumbered and amended to read:

[~~26-34-4~~]. 26B-8-132. Determination of death made by registered nurse.

(1) As used in this section[~~. (a) "Health care facility" means the same as that term is defined in Section 26-21-2. (b) "Physician" means a physician licensed under: (i) Title 58, Chapter 67, Utah Medical Practice Act; or (ii) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act. (c) "Registered~~], "registered nurse" means a registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act.

(2) (a) An individual is dead if the individual has sustained either:

(i) irreversible cessation of circulatory and respiratory functions; or

(ii) irreversible cessation of all functions of the entire brain, including the brain stem.

(b) A determination of death shall be made in accordance with this part and accepted

medical standards.

[~~(2)~~] (3) A registered nurse may make a determination of death of an individual if:

(a) an attending physician has:

(i) documented in the individual's medical or clinical record that the individual's death is anticipated due to illness, infirmity, or disease no later than 180 days after the day on which the physician makes the documentation; and

(ii) established clear assessment procedures for determining death;

(b) the death actually occurs within the 180-day period described in Subsection [~~(2)~~] (3)(a); and

(c) at the time of the documentation described in Subsection [~~(2)~~] (3)(a), the physician authorized the following, in writing, to make the determination of death:

(i) one or more specific registered nurses; or

(ii) if the individual is in a health care facility that has complied with Subsection [~~(5)~~] (6), all registered nurses that the facility employs.

[~~(3)~~] (4) A registered nurse who has determined death under this section shall:

(a) document the clinical criteria for the determination in the individual's medical or clinical record;

(b) notify the physician described in Subsection [~~(2)~~] (3); and

(c) ensure that the death certificate includes:

(i) the name of the deceased;

(ii) the presence of a contagious disease, if known; and

(iii) the date and time of death.

[~~(4)~~] (5) Except as otherwise provided by law or rule, a physician [~~licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act,~~] shall certify a determination of death described in Subsection [~~(3)~~] (4) within 24 hours after the registered nurse makes the determination of death.

[~~(5)~~] (6) (a) For a health care facility to be eligible for a general authorization described in Subsection [~~(2)~~] (3)(c), the facility shall adopt written policies and procedures that provide for the determination of death by a registered nurse under this section.

(b) A registered nurse that a health care facility employs may not make a determination of death under this section unless the facility has adopted the written policies and procedures

described in Subsection [~~(5)~~] (6)(a).

[~~(6)~~] (7) The department may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to ensure the appropriate determination of death under this section.

Section 209. Section **26B-8-133**, which is renumbered from Section 26-23-5 is renumbered and amended to read:

[~~26-23-5~~]. 26B-8-133. Unlawful acts concerning certificates, records, and reports -- Unlawful transportation or acceptance of dead human body.

It is unlawful for any person, association, or corporation and the officers of any of them:

(1) to willfully and knowingly make any false statement in a certificate, record, or report required to be filed with the department, or in an application for a certified copy of a vital record, or to willfully and knowingly supply false information intending that the information be used in the preparation of any report, record, or certificate, or an amendment to any of these;

(2) to make, counterfeit, alter, amend, or mutilate any certificate, record, or report required to be filed under this code or a certified copy of the certificate, record, or report without lawful authority and with the intent to deceive;

(3) to willfully and knowingly obtain, possess, use, sell, furnish, or attempt to obtain, possess, use, sell, or furnish to another, for any purpose of deception, any certificate, record, report, or certified copy of any of them, including any that are counterfeited, altered, amended, or mutilated;

(4) without lawful authority, to possess any certificate, record, or report, required by the department or a copy or certified copy of the certificate, record, or report, knowing it to have been stolen or otherwise unlawfully obtained; or

(5) to willfully and knowingly transport or accept for transportation, interment, or other disposition a dead human body without a permit required by law.

Section 210. Section **26B-8-134**, which is renumbered from Section 26-23-5.5 is renumbered and amended to read:

[~~26-23-5.5~~]. 26B-8-134. Illegal use of birth certificate -- Penalties.

(1) It is a third degree felony for any person to willfully and knowingly:

(a) and with the intent to deceive, obtain, possess, use, sell, furnish, or attempt to

obtain, possess, use, sell, or furnish to another any certificate of birth or certified copy of a certificate of birth knowing that the certificate or certified copy was issued upon information which is false in whole or in part or which relates to the birth of another person, whether living or deceased; or

(b) furnish or process a certificate of birth or certified copy of a certificate of birth with the knowledge or intention that it be used for the purpose of deception by a person other than the person to whom the certificate of birth relates.

(2) The specific criminal violations and the criminal penalty under this section take precedence over any more general criminal offense as described in Section 26-23-5.

Section 211. Section **26B-8-201**, which is renumbered from Section 26-4-2 is renumbered and amended to read:

Part 2. Utah Medical Examiner

[~~26-4-2~~]. 26B-8-201. Definitions.

As used in this [~~chapter~~] part:

(1) "Dead body" means the same as that term is defined in Section 26-2-2.

(2) (a) "Death by violence" means death that resulted by the decedent's exposure to physical, mechanical, or chemical forces.

(b) "Death by violence" includes death that appears to have been due to homicide, death that occurred during or in an attempt to commit rape, mayhem, kidnapping, robbery, burglary, housebreaking, extortion, or blackmail accompanied by threats of violence, assault with a dangerous weapon, assault with intent to commit any offense punishable by imprisonment for more than one year, arson punishable by imprisonment for more than one year, or any attempt to commit any of the foregoing offenses.

(3) "Immediate relative" means an individual's spouse, child, parent, sibling, grandparent, or grandchild.

(4) "Health care professional" means any of the following while acting in a professional capacity:

(a) a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;

(b) a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant Act; or

(c) an advance practice registered nurse licensed under Subsection 58-31b-301(2)(e).

(5) "Medical examiner" means the state medical examiner appointed pursuant to Section 26-4-4 or a deputy appointed by the medical examiner.

(6) "Medical examiner record" means:

(a) all information that the medical examiner obtains regarding a decedent; and

(b) reports that the medical examiner makes regarding a decedent.

(7) "Regional pathologist" means a trained pathologist licensed to practice medicine and surgery in the state, appointed by the medical examiner pursuant to Subsection 26-4-4(3).

(8) "Sudden death while in apparent good health" means apparently instantaneous death without obvious natural cause, death during or following an unexplained syncope or coma, or death during an acute or unexplained rapidly fatal illness.

(9) "Sudden infant death syndrome" means the death of a child who was thought to be in good health or whose terminal illness appeared to be so mild that the possibility of a fatal outcome was not anticipated.

(10) "Suicide" means death caused by an intentional and voluntary act of an individual who understands the physical nature of the act and intends by such act to accomplish self-destruction.

(11) "Unattended death" means a death that occurs more than 365 days after the day on which a health care professional examined or treated the deceased individual for any purpose, including writing a prescription.

(12) (a) "Unavailable for postmortem investigation" means that a dead body is:

(i) transported out of state;

(ii) buried at sea;

(iii) cremated;

(iv) processed by alkaline hydrolysis; or

(v) otherwise made unavailable to the medical examiner for postmortem investigation or autopsy.

(b) "Unavailable for postmortem investigation" does not include embalming or burial of a dead body pursuant to the requirements of law.

(13) "Within the scope of the decedent's employment" means all acts reasonably necessary or incident to the performance of work, including matters of personal convenience

and comfort not in conflict with specific instructions.

Section 212. Section **26B-8-202**, which is renumbered from Section 26-4-4 is renumbered and amended to read:

[~~26-4-4~~]. 26B-8-202. Chief medical examiner -- Appointment -- Qualifications -- Authority.

(1) The executive director, with the advice of an advisory board consisting of the chairman of the Department of Pathology at the University of Utah medical school and the dean of the law school at the University of Utah, shall appoint a chief medical examiner who shall be licensed to practice medicine in the state and shall meet the qualifications of a forensic pathologist, certified by the American Board of Pathologists.

(2) (a) The medical examiner shall serve at the will of the executive director.

(b) The medical examiner has authority to:

(i) employ medical, technical and clerical personnel as may be required to effectively administer this chapter, subject to the rules of the department and the state merit system;

(ii) conduct investigations and pathological examinations;

(iii) perform autopsies authorized in this title;

(iv) conduct or authorize necessary examinations on dead bodies; and

(v) notwithstanding the provisions of Subsection 26-28-122(3), retain tissues and biological samples:

(A) for scientific purposes;

(B) where necessary to accurately certify the cause and manner of death; or

(C) for tissue from an unclaimed body, subject to Section 26-4-25, in order to donate the tissue or biological sample to an individual who is affiliated with an established search and rescue dog organization, for the purpose of training a dog to search for human remains.

(c) In the case of an unidentified body, the medical examiner shall authorize or conduct investigations, tests and processes in order to determine its identity as well as the cause of death.

(3) The medical examiner may appoint regional pathologists, each of whom shall be approved by the executive director.

Section 213. Section **26B-8-203**, which is renumbered from Section 26-4-5 is renumbered and amended to read:

[~~26-4-5~~]. 26B-8-203. County medical examiners.

The county executive, with the advice and consent of the county legislative body, may appoint medical examiners for their respective counties.

Section 214. Section **26B-8-204**, which is renumbered from Section 26-4-6 is renumbered and amended to read:

[~~26-4-6~~]. 26B-8-204. Investigation of deaths -- Requests for autopsies.

(1) The following have authority to investigate a death described in Section 26-4-7 and any other case which may be within their jurisdiction:

(a) the attorney general or an assistant attorney general;

(b) the district attorney or county attorney who has criminal jurisdiction over the death or case;

(c) a deputy of the district attorney or county attorney described in Subsection (1)(b); or

(d) a peace officer within the jurisdiction described in Subsection (1)(b).

(2) If, in the opinion of the medical examiner, an autopsy should be performed or if an autopsy is requested by the district attorney or county attorney having criminal jurisdiction, or by the attorney general, the autopsy shall be performed by the medical examiner or a regional pathologist.

Section 215. Section **26B-8-205**, which is renumbered from Section 26-4-7 is renumbered and amended to read:

[~~26-4-7~~]. 26B-8-205. Custody by medical examiner.

Upon notification under Section 26-4-8 or investigation by the medical examiner's office, the medical examiner shall assume custody of a deceased body if it appears that death:

(1) was by violence, gunshot, suicide, or accident;

(2) was sudden death while in apparent good health;

(3) occurred unattended, except that an autopsy may only be performed in accordance with the provisions of Subsection 26-4-9(3);

(4) occurred under suspicious or unusual circumstances;

(5) resulted from poisoning or overdose of drugs;

(6) resulted from a disease that may constitute a threat to the public health;

(7) resulted from disease, injury, toxic effect, or unusual exertion incurred within the

scope of the decedent's employment;

(8) was due to sudden infant death syndrome;

(9) occurred while the decedent was in prison, jail, police custody, the state hospital, or in a detention or medical facility operated for the treatment of persons with a mental illness, persons who are emotionally disturbed, or delinquent persons;

(10) resulted directly from the actions of a law enforcement officer, as defined in Section 53-13-103;

(11) was associated with diagnostic or therapeutic procedures; or

(12) was described in this section when request is made to assume custody by a county or district attorney or law enforcement agency in connection with a potential homicide investigation or prosecution.

Section 216. Section **26B-8-206**, which is renumbered from Section 26-4-8 is renumbered and amended to read:

[~~26-4-8~~]. 26B-8-206. Discovery of dead body -- Notice requirements -- Procedure.

(1) When death occurs under circumstances listed in Section 26-4-7, the person or persons finding or having custody of the body shall immediately notify the nearest law enforcement agency. The law enforcement agency having jurisdiction over the case shall then proceed to the place where the body is and conduct an investigation concerning the cause and circumstances of death for the purpose of determining whether there exists any criminal responsibility for the death.

(2) On a determination by the law enforcement agency that death may have occurred in any of the ways described in Section 26-4-7, the death shall be reported to the district attorney or county attorney having criminal jurisdiction and to the medical examiner by the law enforcement agency having jurisdiction over the investigation.

(3) The report shall be made by the most expeditious means available. Failure to give notification or report to the district attorney or county attorney having criminal jurisdiction and medical examiner is a class B misdemeanor.

Section 217. Section **26B-8-207**, which is renumbered from Section 26-4-9 is renumbered and amended to read:

[~~26-4-9~~]. 26B-8-207. Custody of dead body and personal effects --

Examination of scene of death -- Preservation of body -- Autopsies.

(1) (a) Upon notification of a death under Section 26-4-8, the medical examiner shall assume custody of the deceased body, clothing on the body, biological samples taken, and any article on or near the body which may aid the medical examiner in determining the cause of death except those articles which will assist the investigative agency to proceed without delay with the investigation.

(b) In all cases the scene of the event may not be disturbed until authorization is given by the senior ranking peace officer from the law enforcement agency having jurisdiction of the case and conducting the investigation.

(c) Where death appears to have occurred under circumstances listed in Section 26-4-7, the person or persons finding or having custody of the body, or jurisdiction over the investigation of the death, shall take reasonable precautions to preserve the body and body fluids so that minimum deterioration takes place.

(d) A person may not move a body in the custody of the medical examiner unless:

(i) the medical examiner, or district attorney or county attorney that has criminal jurisdiction, authorizes the person to move the body;

(ii) a designee of an individual listed in Subsection (1)(d) authorizes the person to move the body;

(iii) not moving the body would be an affront to public decency or impractical; or

(iv) the medical examiner determines the cause of death is likely due to natural causes.

(e) The body can under direction of the medical examiner or the medical examiner's designee be moved to a place specified by the medical examiner or the medical examiner's designee.

(2) (a) If the medical examiner has custody of a body, a person may not clean or embalm the body without first obtaining the medical examiner's permission.

(b) An intentional or knowing violation of Subsection (2)(a) is a class B misdemeanor.

(3) (a) When the medical examiner assumes lawful custody of a body under Subsection 26-4-7(3) solely because the death was unattended, an autopsy may not be performed unless requested by the district attorney, county attorney having criminal jurisdiction, or law enforcement agency having jurisdiction of the place where the body is found.

(b) The county attorney or district attorney and law enforcement agency having

jurisdiction shall consult with the medical examiner to determine the need for an autopsy.

(c) If the deceased chose not to be seen or treated by a health care professional for a spiritual or religious reason, a district attorney, county attorney, or law enforcement agency, may not request an autopsy or inquest under Subsection (3)(a) solely because of the deceased's choice.

(d) The medical examiner or medical examiner's designee may not conduct a requested autopsy described in Subsection (3)(a) if the medical examiner or medical examiner's designee determines:

(i) the request violates Subsection (3)(c); or

(ii) the cause of death can be determined without performing an autopsy.

Section 218. Section **26B-8-208**, which is renumbered from Section 26-2-18.5 is renumbered and amended to read:

[~~26-2-18.5~~]. 26B-8-208. Rendering a dead body unavailable for postmortem investigation.

(1) As used in this section:

(a) "Medical examiner" means the same as that term is defined in Section [~~26-4-2~~] 26B-X-XXX.

(b) "Unavailable for postmortem investigation" means the same as that term is defined in Section [~~26-4-2~~] 26B-X-XXX.

(2) It is unlawful for a person to engage in any conduct that makes a dead body unavailable for postmortem investigation, unless, before engaging in that conduct, the person obtains a permit from the medical examiner to render the dead body unavailable for postmortem investigation, under Section [~~26-4-29~~] 26B-X-XXX, if the person intends to make the body unavailable for postmortem investigation.

(3) A person who violates Subsection (2) is guilty of a third degree felony.

(4) If a person engages in conduct that constitutes both a violation of this section and a violation of Section 76-9-704, the provisions and penalties of Section 76-9-704 supersede the provisions and penalties of this section.

Section 219. Section **26B-8-209**, which is renumbered from Section 26-4-10 is renumbered and amended to read:

[~~26-4-10~~]. 26B-8-209. Certification of cause of death.

(1) (a) For a death under any of the circumstances described in Section 26-4-7, only the medical examiner or the medical examiner's designee may certify the cause of death.

(b) An individual who knowingly certifies the cause of death in violation of Subsection (1)(a) is guilty of a class B misdemeanor.

(2) (a) For a death described in Section 26-4-7, an individual may not knowingly give false information, with the intent to mislead, to the medical examiner or the medical examiner's designee.

(b) A violation of Subsection (2)(a) is a class B misdemeanor.

Section 220. Section **26B-8-210**, which is renumbered from Section 26-4-10.5 is renumbered and amended to read:

[~~26-4-10.5~~]. 26B-8-210. Medical examiner to report death caused by prescribed controlled substance poisoning or overdose.

(1) If a medical examiner determines that the death of a person who is 12 years old or older at the time of death resulted from poisoning or overdose involving a prescribed controlled substance, the medical examiner shall, within three business days after the day on which the medical examiner determines the cause of death, send a written report to the Division of Professional Licensing, created in Section 58-1-103, that includes:

(a) the decedent's name;

(b) each drug or other substance found in the decedent's system that may have contributed to the poisoning or overdose, if known; and

(c) the name of each person the medical examiner has reason to believe may have prescribed a controlled substance described in Subsection (1)(b) to the decedent.

(2) This section does not create a new cause of action.

Section 221. Section **26B-8-211**, which is renumbered from Section 26-4-11 is renumbered and amended to read:

[~~26-4-11~~]. 26B-8-211. Records and reports of investigations.

(1) A complete copy of all written records and reports of investigations and facts resulting from medical care treatment, autopsies conducted by any person on the body of the deceased who died in any manner listed in Section 26-4-7 and the written reports of any investigative agency making inquiry into the incident shall be promptly made and filed with the medical examiner.

(2) The judiciary or a state or local government entity that retains a record, other than a document described in Subsection (1), of the decedent shall provide a copy of the record to the medical examiner:

(a) in accordance with federal law; and

(b) upon receipt of the medical examiner's written request for the record.

(3) Failure to submit reports or records described in Subsection (1) or (2), other than reports of a county attorney, district attorney, or law enforcement agency, within 10 days after the day on which the person in possession of the report or record receives the medical examiner's written request for the report or record is a class B misdemeanor.

Section 222. Section **26B-8-212**, which is renumbered from Section 26-4-12 is renumbered and amended to read:

[~~26-4-12~~]. 26B-8-212. Order to exhume body -- Procedure.

(1) In case of any death described in Section 26-4-7, when a body is buried without an investigation by the medical examiner as to the cause and manner of death, it shall be the duty of the medical examiner, upon being advised of the fact, to notify the district attorney or county attorney having criminal jurisdiction where the body is buried or death occurred. Upon notification, the district attorney or county attorney having criminal jurisdiction may file an action in the district court to obtain an order to exhume the body. A district judge may order the body exhumed upon an ex parte hearing.

(2) (a) A body may not be exhumed until notice of the order has been served upon the executor or administrator of the deceased's estate, or if no executor or administrator has been appointed, upon the nearest heir of the deceased, determined as if the deceased had died intestate. If the nearest heir of the deceased cannot be located within the jurisdiction, then the next heir in succession within the jurisdiction may be served.

(b) The executor, administrator, or heir shall have 24 hours to notify the issuing court of any objection to the order prior to the time the body is exhumed. If no heirs can be located within the jurisdiction within 24 hours, the facts shall be reported to the issuing court which may order that the body be exhumed forthwith.

(c) Notification to the executor, administrator, or heir shall specifically state the nature of the action and the fact that any objection shall be filed with the issuing court within 24 hours of the time of service.

(d) In the event an heir files an objection, the court shall set hearing on the matter at the earliest possible time and issue an order on the matter immediately at the conclusion of the hearing. Upon the receipt of notice of objection, the court shall immediately notify the county attorney who requested the order, so that the interest of the state may be represented at the hearing.

(e) When there is reason to believe that death occurred in a manner described in Section 26-4-7, the district attorney or county attorney having criminal jurisdiction may make a motion that the court, upon ex parte hearing, order the body exhumed forthwith and without notice. Upon a showing of exigent circumstances the court may order the body exhumed forthwith and without notice. In any event, upon motion of the district attorney or county attorney having criminal jurisdiction and upon the personal appearance of the medical examiner, the court for good cause may order the body exhumed forthwith and without notice.

(3) An order to exhume a body shall be directed to the medical examiner, commanding the medical examiner to cause the body to be exhumed, perform the required autopsy, and properly cause the body to be reburied upon completion of the examination.

(4) The examination shall be completed and the complete autopsy report shall be made to the district attorney or county attorney having criminal jurisdiction for any action the attorney considers appropriate. The district attorney or county attorney shall submit the return of the order to exhume within 10 days in the manner prescribed by the issuing court.

Section 223. Section **26B-8-213**, which is renumbered from Section 26-4-13 is renumbered and amended to read:

[~~26-4-13~~]. 26B-8-213. Autopsies -- When authorized.

(1) The medical examiner shall perform an autopsy to:

(a) aid in the discovery and prosecution of a crime;

(b) protect an innocent person accused of a crime; and

(c) disclose hazards to public health.

(2) The medical examiner may perform an autopsy:

(a) to aid in the administration of civil justice in life and accident insurance problems in accordance with Title 34A, Chapter 2, Workers' Compensation Act;

(b) in other cases involving questions of civil liability.

Section 224. Section **26B-8-214**, which is renumbered from Section 26-4-14 is

renumbered and amended to read:

[~~26-4-14~~]. 26B-8-214. Certification of death by attending health care professional -- Deaths without medical attendance -- Cause of death uncertain -- Notice requirements.

(1) (a) A health care professional who treats or examines an individual within 365 days from the day on which the individual dies, shall certify the individual's cause of death to the best of the health care professional's knowledge and belief unless the health care professional determines the individual may have died in a manner described in Section 26-4-7.

(b) If a health care professional is unable to determine an individual's cause of death in accordance with Subsection (1)(a), the health care professional shall notify the medical examiner.

(2) For an unattended death, the person with custody of the body shall notify the medical examiner of the death.

(3) If the medical examiner determines there may be criminal responsibility for a death, the medical examiner shall notify:

(a) the district attorney or county attorney that has criminal jurisdiction; or

(b) the head of the law enforcement agency that has jurisdiction to investigate the death.

Section 225. Section **26B-8-215**, which is renumbered from Section 26-4-15 is renumbered and amended to read:

[~~26-4-15~~]. 26B-8-215. Deaths in medical centers and federal facilities.

All death certificates of any decedent who died in a teaching medical center or a federal medical facility unattended or in the care of an unlicensed physician or other medical personnel shall be signed by the licensed supervisory physician, attending physician or licensed resident physician of the medical center or facility.

Section 226. Section **26B-8-216**, which is renumbered from Section 26-4-16 is renumbered and amended to read:

[~~26-4-16~~]. 26B-8-216. Release of body for funeral preparations.

(1) (a) Where a body is held for investigation or autopsy under this chapter or for a medical investigation permitted by law, the body shall, if requested by the person given priority under Section 58-9-602, be released for funeral preparations no later than 24 hours after the

arrival at the office of the medical examiner or regional medical facility.

(b) An extension may be ordered only by a district court.

(2) The right and duty to control the disposition of a deceased person is governed by Sections 58-9-601 through 58-9-606.

Section 227. Section **26B-8-217**, which is renumbered from Section 26-4-17 is renumbered and amended to read:

[~~26-4-17~~]. 26B-8-217. Records of medical examiner -- Confidentiality.

(1) The medical examiner shall maintain complete, original records for the medical examiner record, which shall:

(a) be properly indexed, giving the name, if known, or otherwise identifying every individual whose death is investigated;

(b) indicate the place where the body was found;

(c) indicate the date of death;

(d) indicate the cause and manner of death;

(e) indicate the occupation of the decedent, if available;

(f) include all other relevant information concerning the death; and

(g) include a full report and detailed findings of the autopsy or report of the investigation.

(2) (a) Upon written request from an individual described in Subsections (2)(a)(i) through (iv), the medical examiner shall provide a copy of the medical examiner's final report of examination for the decedent, including the autopsy report, toxicology report, lab reports, and investigative reports to any of the following:

(i) a decedent's immediate relative;

(ii) a decedent's legal representative;

(iii) a physician or physician assistant who attended the decedent during the year before the decedent's death; or

(iv) a county attorney, a district attorney, a criminal defense attorney, or other law enforcement official with jurisdiction, as necessary for the performance of the attorney or official's professional duties.

(b) Upon written request from the director or a designee of the director of an entity described in Subsections (2)(b)(i) through (iv), the medical examiner may provide a copy of the

of the medical examiner's final report of examination for the decedent, including any other reports described in Subsection (2)(a), to any of the following entities as necessary for performance of the entity's official purposes:

(i) a local health department;

(ii) a local mental health authority;

(iii) a public health authority; or

(iv) another state or federal governmental agency.

(c) The medical examiner may provide a copy of the medical examiner's final report of examination, including any other reports described in Subsection (2)(a), if the final report relates to an issue of public health or safety, as further defined by rule made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) Reports provided under Subsection (2) may not include records that the medical examiner obtains from a third party in the course of investigating the decedent's death.

(4) The medical examiner may provide a medical examiner record to a researcher who:

(a) has an advanced degree;

(b) (i) is affiliated with an accredited college or university, a hospital, or another system of care, including an emergency medical response or a local health agency; or

(ii) is part of a research firm contracted with an accredited college or university, a hospital, or another system of care;

(c) requests a medical examiner record for a research project or a quality improvement initiative that will have a public health benefit, as determined by the department; and

(d) provides to the medical examiner an approval from:

(i) the researcher's sponsoring organization; and

(ii) the Utah Department of Health and Human Services Institutional Review Board.

(5) Records provided under Subsection (4) may not include a third party record, unless:

(a) a court has ordered disclosure of the third party record; and

(b) disclosure is conducted in compliance with state and federal law.

(6) A person who obtains a medical examiner record under Subsection (4) shall:

(a) maintain the confidentiality of the medical examiner record by removing personally identifying information about a decedent or the decedent's family and any other information that may be used to identify a decedent before using the medical examiner record in research;

(b) conduct any research within and under the supervision of the Office of the Medical Examiner, if the medical examiner record contains a third party record with personally identifiable information;

(c) limit the use of a medical examiner record to the purpose for which the person requested the medical examiner record;

(d) destroy a medical examiner record and the data abstracted from the medical examiner record at the conclusion of the research for which the person requested the medical examiner record;

(e) reimburse the medical examiner, as provided in Section 26B-1-209, for any costs incurred by the medical examiner in providing a medical examiner record;

(f) allow the medical examiner to review, before public release, a publication in which data from a medical examiner record is referenced or analyzed; and

(g) provide the medical examiner access to the researcher's database containing data from a medical examiner record, until the day on which the researcher permanently destroys the medical examiner record and all data obtained from the medical examiner record.

(7) The department may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consideration of applicable state and federal law, to establish permissible uses and disclosures of a medical examiner record or other record obtained under this section.

(8) Except as provided in this chapter or ordered by a court, the medical examiner may not disclose any part of a medical examiner record.

(9) A person who obtains a medical examiner record under Subsection (4) is guilty of a class B misdemeanor, if the person fails to comply with the requirements of Subsections (6)(a) through (d).

Section 228. Section **26B-8-218**, which is renumbered from Section 26-4-18 is renumbered and amended to read:

[~~26-4-18~~]. 26B-8-218. Records of medical examiner -- Admissibility as evidence -- Subpoena of person who prepared record.

The records of the medical examiner or transcripts thereof certified by the medical examiner are admissible as evidence in any civil action in any court in this state except that statements by witnesses or other persons, unless taken pursuant to Section 26-4-21, as

conclusions upon extraneous matters are not hereby made admissible. The person who prepared a report or record offered in evidence hereunder may be subpoenaed as a witness in the case by any party.

Section 229. Section **26B-8-219**, which is renumbered from Section 26-4-19 is renumbered and amended to read:

[~~26-4-19~~]. 26B-8-219. Personal property of deceased -- Disposition.

(1) Personal property of the deceased not held as evidence shall be turned over to the legal representative of the deceased within 30 days after completion of the investigation of the death of the deceased. If no legal representative is known, the county attorney, district attorney, or the medical examiner shall, within 30 days after the investigation, turn the personal property over to the county treasurer to be handled pursuant to the escheat laws.

(2) An affidavit shall be filed with the county treasurer by the county attorney, district attorney, or the medical examiner within 30 days after investigation of the death of the deceased showing the money or other property belonging to the estate of the deceased person which has come into his possession and the disposition made of the property.

(3) Property required to be turned over to the legal representative of the deceased may be held longer than 30 days if, in the opinion of the county attorney, district attorney, or attorney general, the property is necessary evidence in a court proceeding. Upon conclusion of the court proceedings, the personal property shall be turned over as described in this section and in accordance with the rules of the court.

Section 230. Section **26B-8-220**, which is renumbered from Section 26-4-20 is renumbered and amended to read:

[~~26-4-20~~]. 26B-8-220. Officials not liable for authorized acts.

Except as provided in this [~~chapter~~] part, a criminal or civil action may not arise against the county attorney, district attorney, or his deputies, the medical examiner or his deputies, or regional pathologists for authorizing or performing autopsies authorized by this [~~chapter~~] part or for any other act authorized by this [~~chapter~~] part.

Section 231. Section **26B-8-221**, which is renumbered from Section 26-4-21 is renumbered and amended to read:

[~~26-4-21~~]. 26B-8-221. Authority of county attorney or district attorney to subpoena witnesses and compel testimony -- Determination if decedent died by unlawful

means.

(1) The district attorney or county attorney having criminal jurisdiction may subpoena witnesses and compel testimony concerning the death of any person and have such testimony reduced to writing under his direction and may employ a shorthand reporter for that purpose at the same compensation as is allowed to reporters in the district courts. When the testimony has been taken down by the shorthand reporter, a transcript thereof, duly certified, shall constitute the deposition of the witness.

(2) Upon review of all facts and testimony taken concerning the death of a person, the district attorney or county attorney having criminal jurisdiction shall determine if the decedent died by unlawful means and shall also determine if criminal prosecution shall be instituted.

Section 232. Section **26B-8-222**, which is renumbered from Section 26-4-22 is renumbered and amended to read:

[~~26-4-22~~]. 26B-8-222. Additional powers and duties of department.

The department may:

(1) establish rules to carry out the provisions of this chapter;

(2) arrange for the state health laboratory to perform toxicologic analysis for public or private institutions and fix fees for the services;

(3) cooperate and train law enforcement personnel in the techniques of criminal investigation as related to medical and pathological matters; and

(4) pay to private parties, institutions or funeral directors the reasonable value of services performed for the medical examiner's office.

Section 233. Section **26B-8-223**, which is renumbered from Section 26-4-23 is renumbered and amended to read:

[~~26-4-23~~]. 26B-8-223. Authority of examiner to provide organ or other tissue for transplant purposes.

(1) When requested by the licensed physician of a patient who is in need of an organ or other tissue for transplant purpose, by a legally created Utah eye bank, organ bank or medical facility, the medical examiner may provide an organ or other tissue if:

(a) a decedent who may provide a suitable organ or other tissue for the transplant is in the custody of the medical examiner;

(b) the medical examiner is assured that the requesting party has made reasonable

search for and inquiry of next of kin of the decedent and that no objection by the next of kin is known by the requesting party; and

(c) the removal of the organ or other tissue will not interfere with the investigation or autopsy or alter the post-mortem facial appearance.

(2) When the medical examiner is in custody of a decedent who may provide a suitable organ or other tissue for transplant purposes, he may contact the appropriate eye bank, organ bank or medical facility and notify them concerning the suitability of the organ or other tissue. In such contact the medical examiner may disclose the name of the decedent so that necessary clearances can be obtained.

(3) No person shall be held civilly or criminally liable for any acts performed pursuant to this section.

Section 234. Section **26B-8-224**, which is renumbered from Section 26-4-24 is renumbered and amended to read:

[~~26-4-24~~]. 26B-8-224. Autopsies -- Persons eligible to authorize.

(1) Autopsies may be authorized:

(a) by the commissioner of the Labor Commission or the commissioner's designee as provided in Section 34A-2-603;

(b) by individuals by will or other written document;

(c) upon a decedent by the next of kin in the following order and as known: surviving spouse, child, if 18 years or older, otherwise the legal guardian of the child, parent, sibling, uncle or aunt, nephew or niece, cousin, others charged by law with the duty of burial, or friend assuming the obligation of burial;

(d) by the county attorney, district attorney, or the district attorney's deputy, or a district judge; and

(e) by the medical examiner as provided in this chapter.

(2) Autopsies authorized under Subsections (1)(a) and (1)(d) shall be performed by a certified pathologist.

(3) No criminal or civil action arises against a pathologist or a physician who proceeds in good faith and performs an autopsy authorized by this section.

Section 235. Section **26B-8-225**, which is renumbered from Section 26-4-25 is renumbered and amended to read:

[~~26-4-25~~]. 26B-8-225. Burial of an unclaimed body -- Request by the school of medicine at the University of Utah -- Medical examiner may retain tissue for dog training.

(1) Except as described in Subsection (2) or (3), a county shall provide, at the county's expense, decent burial for an unclaimed body found in the county.

(2) A county is not responsible for decent burial of an unclaimed body found in the county if the body is requested by the dean of the school of medicine at the University of Utah under Section 53B-17-301.

(3) For an unclaimed body that is temporarily in the medical examiner's custody before burial under Subsection (1), the medical examiner may retain tissue from the unclaimed body in order to donate the tissue to an individual who is affiliated with an established search and rescue dog organization, for the purpose of training a dog to search for human remains.

Section 236. Section **26B-8-226**, which is renumbered from Section 26-4-26 is renumbered and amended to read:

[~~26-4-26~~]. 26B-8-226. Social security number in certification of death.

A certification of death shall include, if known, the social security number of the deceased person, and a copy of the certification shall be sent to the Office of Recovery Services within the [~~Department of Human Services~~] department upon request.

Section 237. Section **26B-8-227**, which is renumbered from Section 26-4-27 is renumbered and amended to read:

[~~26-4-27~~]. 26B-8-227. Registry of unidentified deceased persons.

(1) If the identity of a deceased person over which the medical examiner has jurisdiction under Section 26-4-7 is unknown, the medical examiner shall do the following before releasing the body to the county in which the body was found as provided in Section 26-4-25:

(a) assign a unique identifying number to the body;

(b) create and maintain a file under the assigned number;

(c) examine the body, take samples, and perform other related tasks for the purpose of deriving information that may be useful in ascertaining the identity of the deceased person;

(d) use the identifying number in all records created by the medical examiner that pertains to the body;

(e) record all information pertaining to the body in the file created and maintained under Subsection (1)(b);

(f) communicate the unique identifying number to the county in which the body was found; and

(g) access information from available government sources and databases in an attempt to ascertain the identity of the deceased person.

(2) A county which has received a body to which Subsection (1) applies:

(a) shall adopt and use the same identifying number assigned by Subsection (1) in all records created by the county that pertain to the body;

(b) require any funeral director or sexton who is involved in the disposition of the body to adopt and use the same identifying number assigned by Subsection (1) in all records created by the funeral director or sexton pertaining to the body; and

(c) shall provide a decent burial for the body.

(3) Within 30 days of receiving a body to which Subsection (1) applies, the county shall inform the medical examiner of the disposition of the body including the burial plot. The medical examiner shall record this information in the file created and maintained under Subsection (1)(b).

(4) The requirements of Subsections (1) and (6) apply to a county examiner appointed under Section 26-4-5, with the additional requirements that the county examiner:

(a) obtain a unique identifying number from the medical examiner for the body; and

(b) send to the medical examiner a copy of the file created and maintained in accordance with Subsection (1)(b), including the disposition of the body and burial plot, within 30 days of releasing the body.

(5) The medical examiner shall maintain a file received under Subsection (4) in the same way that it maintains a file created and maintained by the medical examiner in accordance with Subsection (1)(b).

(6) The medical examiner shall cooperate and share information generated and maintained under this section with a person who demonstrates:

(a) a legitimate personal or governmental interest in determining the identity of a deceased person; and

(b) a reasonable belief that the body of that deceased person may have come into the

custody of the medical examiner.

Section 238. Section **26B-8-228**, which is renumbered from Section 26-4-28 is renumbered and amended to read:

[~~26-4-28~~]. 26B-8-228. Testing for suspected suicides -- Maintaining information -- Compensation to deputy medical examiners.

(1) In all cases where it is suspected that a death resulted from suicide, including assisted suicide, the medical examiner shall endeavor to have the following tests conducted upon samples taken from the body of the deceased:

(a) a test that detects all of the substances included in the volatiles panel of the Bureau of Forensic Toxicology within the Department of Health;

(b) a test that detects all of the substances included in the drugs of abuse panel of the Bureau of Forensic Toxicology within the Department of Health; and

(c) a test that detects all of the substances included in the prescription drug panel of the Bureau of Forensic Toxicology within the Department of Health.

(2) The medical examiner shall maintain information regarding the types of substances found present in the samples taken from the body of a person who is suspected to have died as a result of suicide or assisted suicide.

(3) Within funds appropriated by the Legislature for this purpose, the medical examiner shall provide compensation, at a standard rate determined by the medical examiner, to a deputy medical examiner who collects samples for the purposes described in Subsection (1).

Section 239. Section **26B-8-229**, which is renumbered from Section 26-4-28.5 is renumbered and amended to read:

[~~26-4-28.5~~]. 26B-8-229. Psychological autopsy examiner.

(1) With funds appropriated by the Legislature for this purpose, the department shall provide compensation, at a standard rate determined by the department, to a psychological autopsy examiner.

(2) The psychological autopsy examiner shall:

(a) work with the medical examiner to compile data regarding suicide related deaths;

(b) as relatives of the deceased are willing, gather information from relatives of the deceased regarding the psychological reasons for the decedent's death;

(c) maintain a database of information described in Subsections (2)(a) and (b);

(d) in accordance with all applicable privacy laws subject to approval by the department, share the database described in Subsection (2)(c) with the University of Utah Department of Psychiatry or other university-based departments conducting research on suicide;

(e) coordinate no less than monthly with the suicide prevention coordinator described in Subsection 62A-15-1101(2); and

(f) coordinate no less than quarterly with the state suicide prevention coalition.

Section 240. Section **26B-8-230**, which is renumbered from Section 26-4-29 is renumbered and amended to read:

[~~26-4-29~~]. 26B-8-230. Application for permit to render a dead body unavailable for postmortem examination -- Fees.

(1) Upon receiving an application by a person for a permit to render a dead body unavailable for postmortem investigation, the medical examiner shall review the application to determine whether:

(a) the person is authorized by law to render the dead body unavailable for postmortem investigation in the manner specified in the application; and

(b) there is a need to delay any action that will render the dead body unavailable for postmortem investigation until a postmortem investigation or an autopsy of the dead body is performed by the medical examiner.

(2) Except as provided in Subsection (4), within three days after receiving an application described in Subsection (1), the medical examiner shall:

(a) make the determinations described in Subsection (1); and

(b) (i) issue a permit to render the dead body unavailable for postmortem investigation in the manner specified in the application; or

(ii) deny the permit.

(3) The medical examiner may deny a permit to render a dead body unavailable for postmortem investigation only if:

(a) the applicant is not authorized by law to render the dead body unavailable for postmortem investigation in the manner specified in the application;

(b) the medical examiner determines that there is a need to delay any action that will

render the dead body unavailable for postmortem investigation; or

(c) the applicant fails to pay the fee described in Subsection (5).

(4) If the medical examiner cannot in good faith make the determinations described in Subsection (1) within three days after receiving an application described in Subsection (1), the medical examiner shall notify the applicant:

(a) that more time is needed to make the determinations described in Subsection (1); and

(b) of the estimated amount of time needed before the determinations described in Subsection (1) can be made.

(5) The medical examiner may charge a fee, pursuant to Section 63J-1-504, to recover the costs of fulfilling the duties of the medical examiner described in this section.

Section 241. Section **26B-8-231**, which is renumbered from Section 26-4-30 is renumbered and amended to read:

[~~26-4-30~~]. 26B-8-231. Overdose fatality examiner.

(1) Within funds appropriated by the Legislature, the department shall provide compensation, at a standard rate determined by the department, to an overdose fatality examiner.

(2) The overdose fatality examiner shall:

(a) work with the medical examiner to compile data regarding overdose and opioid related deaths, including:

(i) toxicology information;

(ii) demographics; and

(iii) the source of opioids or drugs;

(b) as relatives of the deceased are willing, gather information from relatives of the deceased regarding the circumstances of the decedent's death;

(c) maintain a database of information described in Subsections (2)(a) and (b);

(d) coordinate no less than monthly with the suicide prevention coordinator described in Section 62A-15-1101; and

(e) coordinate no less than quarterly with the Opioid and Overdose Fatality Review Committee created in Section 26-7-13.

Section 242. Section **26B-8-301**, which is renumbered from Section 26-28-102 is

renumbered and amended to read:

Part 3. Revised Uniform Anatomical Gift Act

[~~26-28-102~~]. 26B-8-301. Definitions.

As used in this [~~chapter~~] part:

(1) "Adult" means an individual who is at least 18 years of age.

(2) "Agent" means an individual:

(a) authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or

(b) expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

(4) "Decedent" means:

(a) a deceased individual whose body or part is or may be the source of an anatomical gift; and

(b) includes:

(i) a stillborn infant; and

(ii) subject to restrictions imposed by law other than this chapter, a fetus.

(5) (a) "Disinterested witness" means:

(i) a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift; or

(ii) another adult who exhibited special care and concern for the individual.

(b) "Disinterested witness" does not include a person to which an anatomical gift could pass under Section 26-28-111.

(6) "Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a driver license, identification card, or donor registry.

(7) "Donor" means an individual whose body or part is the subject of an anatomical gift.

(8) "Donor registry" means a database that contains records of anatomical gifts and

amendments to or revocations of anatomical gifts.

(9) "Driver license" means a license or permit issued by the Driver License Division of the Department of Public Safety, to operate a vehicle, whether or not conditions are attached to the license or permit.

(10) "Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.

(11) "Guardian":

(a) means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual; and

(b) does not include a guardian ad litem.

(12) "Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

(13) "Identification card" means an identification card issued by the Driver License Division of the Department of Public Safety.

(14) "Know" means to have actual knowledge.

(15) "Minor" means an individual who is under 18 years of age.

(16) "Organ procurement organization" means a person designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization.

(17) "Parent" means a parent whose parental rights have not been terminated.

(18) "Part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

(19) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(20) "Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

(21) "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

(22) "Prospective donor":

(a) means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education; and

(b) does not include an individual who has made a refusal.

(23) "Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

(24) "Recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted.

(25) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(26) "Refusal" means a record created under Section 26-28-107 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part.

(27) "Sign" means, with the present intent to authenticate or adopt a record:

(a) to execute or adopt a tangible symbol; or

(b) to attach to or logically associate with the record an electronic symbol, sound, or process.

(28) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(29) "Technician":

(a) means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law; and

(b) includes an enucleator.

(30) "Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

(31) "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

(32) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

Section 243. Section **26B-8-302**, which is renumbered from Section 26-28-103 is renumbered and amended to read:

[~~26-28-103~~]. 26B-8-302. Applicability.

This [~~chapter~~] part applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

Section 244. Section **26B-8-303**, which is renumbered from Section 26-28-104 is renumbered and amended to read:

[~~26-28-104~~]. 26B-8-303. Who may make anatomical gift before donor's death.

Subject to Section 26-28-108, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in Section 26-28-105 by:

(1) the donor, if the donor is an adult or if the donor is a minor and is:

(a) emancipated; or

(b) authorized under state law to apply for a driver license because the donor is at least 15 years of age;

(2) an agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

(3) a parent of the donor, if the donor is an unemancipated minor; or

(4) the donor's guardian.

Section 245. Section **26B-8-304**, which is renumbered from Section 26-28-105 is renumbered and amended to read:

[~~26-28-105~~]. 26B-8-304. Manner of making anatomical gift before donor's death.

(1) A donor may make an anatomical gift:

(a) by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver license or identification card;

(b) in a will;

(c) during a terminal illness or injury of the donor, by any form of communication

addressed to at least two adults, at least one of whom is a disinterested witness; or

(d) as provided in Subsection (2).

(2) A donor or other person authorized to make an anatomical gift under Section 26-28-104 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and shall:

(a) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(b) state that it has been signed and witnessed as provided in Subsection (2)(a).

(3) Revocation, suspension, expiration, or cancellation of a driver license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

(4) An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

Section 246. Section **26B-8-305**, which is renumbered from Section 26-28-106 is renumbered and amended to read:

[~~26-28-106~~]. 26B-8-305. Amending or revoking anatomical gift before donor's death.

(1) Subject to Section 26-28-108, a donor or other person authorized to make an anatomical gift under Section 26-28-104 may amend or revoke an anatomical gift by:

(a) a record signed by:

(i) the donor;

(ii) the other person; or

(iii) subject to Subsection (2), another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

(b) a later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

(2) A record signed pursuant to Subsection (1)(a)(iii) shall:

(a) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

(b) state that it has been signed and witnessed as provided in Subsection (1)(a).

(3) Subject to Section 26-28-108, a donor or other person authorized to make an anatomical gift under Section 26-28-104 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

(4) A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(5) A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in Subsection (1).

Section 247. Section **26B-8-306**, which is renumbered from Section 26-28-107 is renumbered and amended to read:

[~~26-28-107~~]. 26B-8-306. Refusal to make anatomical gift -- Effect of refusal.

(1) An individual may refuse to make an anatomical gift of the individual's body or part by:

(a) a record signed by:

(i) the individual; or

(ii) subject to Subsection (2), another individual acting at the direction of the individual if the individual is physically unable to sign;

(b) the individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

(c) any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

(2) A record signed pursuant to Subsection (1)(a)(ii) shall:

(a) be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

(b) state that it has been signed and witnessed as provided in Subsection (1)(a).

(3) An individual who has made a refusal may amend or revoke the refusal:

(a) in the manner provided in Subsection (1) for making a refusal;

(b) by subsequently making an anatomical gift pursuant to Section 26-28-105 that is

inconsistent with the refusal; or

(c) by destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

(4) Except as otherwise provided in Subsection 26-28-108(8), in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars all other persons from making an anatomical gift of the individual's body or part.

Section 248. Section **26B-8-307**, which is renumbered from Section 26-28-108 is renumbered and amended to read:

[~~26-28-108~~]. 26B-8-307. Preclusive effect of anatomical gift, amendment, or revocation.

(1) Except as otherwise provided in Subsection (7) and subject to Subsection (6), in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part under Section 26-28-105 or an amendment to an anatomical gift of the donor's body or part under Section 26-28-106.

(2) A donor's revocation of an anatomical gift of the donor's body or part under Section 26-28-106 is not a refusal and does not bar another person specified in Section 26-28-104 or 26-28-109 from making an anatomical gift of the donor's body or part under Section 26-28-105 or 26-28-110.

(3) If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part under Section 26-28-105 or an amendment to an anatomical gift of the donor's body or part under Section 26-28-106, another person may not make, amend, or revoke the gift of the donor's body or part under Section 26-28-110.

(4) A revocation of an anatomical gift of a donor's body or part under Section 26-28-106 by a person other than the donor does not bar another person from making an anatomical gift of the body or part under Section 26-28-105 or 26-28-110.

(5) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under Section 26-28-104, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

(6) In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under Section 26-28-104, an anatomical gift of a part for one or more of the purposes set forth in Section 26-28-104 is not a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or any other person under Section 26-28-105 or 26-28-110.

(7) If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

(8) If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

Section 249. Section **26B-8-308**, which is renumbered from Section 26-28-109 is renumbered and amended to read:

[~~26-28-109~~]. 26B-8-308. Who may make anatomical gift of decedent's body or part.

(1) Subject to Subsections (2) and (3) and unless barred by Section 26-28-107 or 26-28-108, an anatomical gift of a decedent's body or part for purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

(a) an agent of the decedent at the time of death who could have made an anatomical gift under Subsection 26-28-104(2) immediately before the decedent's death;

(b) the spouse of the decedent;

(c) adult children of the decedent;

(d) parents of the decedent;

(e) adult siblings of the decedent;

(f) adult grandchildren of the decedent;

(g) grandparents of the decedent;

(h) the persons who were acting as the guardians of the person of the decedent at the time of death;

(i) an adult who exhibited special care and concern for the decedent; and

(j) any other person having the authority to dispose of the decedent's body.

(2) If there is more than one member of a class listed in Subsection (1)(a), (c), (d), (e), (f), (g), or (j) entitled to make an anatomical gift, an anatomical gift may be made by a member

of the class unless that member or a person to which the gift may pass under Section 26-28-111 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

(3) A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under Subsection (1) is reasonably available to make or to object to the making of an anatomical gift.

Section 250. Section **26B-8-309**, which is renumbered from Section 26-28-110 is renumbered and amended to read:

[~~26-28-110~~]. 26B-8-309. Manner of making, amending, or revoking anatomical gift of decedent's body or part.

(1) A person authorized to make an anatomical gift under Section 26-28-109 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

(2) Subject to Subsection (3), an anatomical gift by a person authorized under Section 26-28-109 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under Section 26-28-109 may be:

(a) amended only if a majority of the reasonably available members agree to the amending of the gift; or

(b) revoked only if a majority of the reasonably available members agree to the revoking of the gift or if they are equally divided as to whether to revoke the gift.

(3) A revocation under Subsection (2) is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

Section 251. Section **26B-8-310**, which is renumbered from Section 26-28-111 is renumbered and amended to read:

[~~26-28-111~~]. 26B-8-310. Persons that may receive anatomical gift -- Purpose of anatomical gift.

(1) An anatomical gift may be made to the following persons named in the document

of gift:

(a) a hospital, accredited medical school, dental school, college, university, organ procurement organization, or other appropriate person, for research or education;

(b) subject to Subsection (2), an individual designated by the person making the anatomical gift if the individual is the recipient of the part; or

(c) an eye bank or tissue bank.

(2) If an anatomical gift to an individual under Subsection (1)(b) cannot be transplanted into the individual, the part passes in accordance with Subsection (7) in the absence of an express, contrary indication by the person making the anatomical gift.

(3) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in Subsection (1) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(a) If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

(b) If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

(c) If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(d) If the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(4) For the purpose of Subsection (3), if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift shall be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(5) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in Subsection (1) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with Subsection (7).

(6) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in

accordance with Subsection (7).

(7) For purposes of Subsections (2), (5), and (7) the following rules apply:

(a) If the part is an eye, the gift passes to the appropriate eye bank.

(b) If the part is tissue, the gift passes to the appropriate tissue bank.

(c) If the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(8) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under Subsection (1)(b), passes to the organ procurement organization as custodian of the organ.

(9) If an anatomical gift does not pass pursuant to Subsections (2) through (8) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

(10) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under Section 26-28-105 or 26-28-110 or if the person knows that the decedent made a refusal under Section 26-28-107 that was not revoked. For purposes of this Subsection (10), if a person knows that an anatomical gift was made on a document of gift, the person is considered to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(11) Except as otherwise provided in Subsection (1)(b), nothing in this chapter affects the allocation of organs for transplantation or therapy.

Section 252. Section **26B-8-311**, which is renumbered from Section 26-28-112 is renumbered and amended to read:

[~~26-28-112~~]. 26B-8-311. Search and notification.

(1) The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or near death for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

(a) a law enforcement officer, firefighter, paramedic, or other emergency rescuer finding the individual;

(b) if no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital; and

(c) a law enforcement officer, firefighter, emergency medical services provider, or

other emergency rescuer who finds an individual who is deceased at the scene of a motor vehicle accident, when the deceased individual is transported from the scene of the accident to a funeral establishment licensed under Title 58, Chapter 9, Funeral Services Licensing Act:

(i) the law enforcement officer, firefighter, emergency medical services provider, or other emergency rescuer shall as soon as reasonably possible, notify the appropriate organ procurement organization, tissue bank, or eye bank of:

(A) the identity of the deceased individual, if known;

(B) information, if known, pertaining to the deceased individual's legal next-of-kin in accordance with Section 26-28-109; and

(C) the name and location of the funeral establishment which received custody of and transported the deceased individual; and

(ii) the funeral establishment receiving custody of the deceased individual under this Subsection (1)(c) may not embalm the body of the deceased individual until:

(A) the funeral establishment receives notice from the organ procurement organization, tissue bank, or eye bank that the readily available persons listed as having priority in Section 26-28-109 have been informed by the organ procurement organization of the option to make or refuse to make an anatomical gift in accordance with Section 26-28-104, with reasonable discretion and sensitivity appropriate to the circumstances of the family;

(B) in accordance with federal law, prior approval for embalming has been obtained from a family member or other authorized person; and

(C) the period of time in which embalming is prohibited under Subsection (1)(c)(ii) may not exceed 24 hours after death.

(2) If a document of gift or a refusal to make an anatomical gift is located by the search required by Subsection (1)(a) and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

(3) A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

Section 253. Section **26B-8-312**, which is renumbered from Section 26-28-113 is renumbered and amended to read:

[~~26-28-113~~]. 26B-8-312. Delivery of document of gift not required -- Right

to examine.

(1) A document of gift need not be delivered during the donor's lifetime to be effective.

(2) Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under Section 26-28-111.

Section 254. Section **26B-8-313**, which is renumbered from Section 26-28-114 is renumbered and amended to read:

[~~26-28-114~~]. 26B-8-313. Rights and duties of procurement organization and others.

(1) When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of the records of the Department of Public Safety and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

(2) A procurement organization shall be allowed reasonable access to information in the records of the Department of Public Safety to ascertain whether an individual at or near death is a donor.

(3) When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

(4) Unless prohibited by law other than this chapter, at any time after a donor's death, the person to which a part passes under Section 26-28-111 may conduct any reasonable examination necessary to ensure the medical suitability of the body or part for its intended purpose.

(5) Unless prohibited by law other than this chapter, an examination under Subsection (3) or (4) may include an examination of all medical and dental records of the donor or

prospective donor.

(6) Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

(7) Upon referral by a hospital under Subsection (1), a procurement organization shall make a reasonable search for any person listed in Section 26-28-109 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

(8) Subject to Subsection 26-28-111(9) and Section 26-28-123, the rights of the person to which a part passes under Section 26-28-111 are superior to the rights of all others with respect to the part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and this chapter, a person that accepts an anatomical gift of an entire body may allow embalming, burial or cremation, and use of remains in a funeral service. If the gift is of a part, the person to which the part passes under Section 26-28-111, upon the death of the donor and before embalming, burial, or cremation, shall cause the part to be removed without unnecessary mutilation.

(9) Neither the physician or physician assistant who attends the decedent at death nor the physician or physician assistant who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

(10) A physician, physician assistant, or technician may remove a donated part from the body of a donor that the physician, physician assistant, or technician is qualified to remove.

Section 255. Section **26B-8-314**, which is renumbered from Section 26-28-115 is renumbered and amended to read:

[~~26-28-115~~]. 26B-8-314. Coordination of procurement and use.

Each hospital in this state shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

Section 256. Section **26B-8-315**, which is renumbered from Section 26-28-116 is renumbered and amended to read:

[~~26-28-116~~]. 26B-8-315. Sale or purchase of parts prohibited.

(1) Except as otherwise provided in Subsection (2), a person that for valuable consideration, knowingly purchases or sells a part for transplantation or therapy if removal of a part from an individual is intended to occur after the individual's death commits a third degree felony.

(2) A person may charge a reasonable amount for the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a part.

Section 257. Section **26B-8-316**, which is renumbered from Section 26-28-117 is renumbered and amended to read:

[~~26-28-117~~]. 26B-8-316. Other prohibited acts.

A person that, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces, or obliterates a document of gift, an amendment, or revocation of a document of gift, or a refusal commits a third degree felony.

Section 258. Section **26B-8-317**, which is renumbered from Section 26-28-118 is renumbered and amended to read:

[~~26-28-118~~]. 26B-8-317. Immunity.

(1) A person that acts in accordance with this chapter or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

(2) Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

(3) In determining whether an anatomical gift has been made, amended, or revoked under this chapter, a person may rely upon representations of an individual listed in Subsection 26-28-109(1)(b), (c), (d), (e), (f), (g), (h), (i), or (j) relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

Section 259. Section **26B-8-318**, which is renumbered from Section 26-28-119 is renumbered and amended to read:

[~~26-28-119~~]. 26B-8-318. Law governing validity -- Choice of law as to execution of document of gift -- Presumption of validity.

(1) A document of gift is valid if executed in accordance with:

(a) this chapter;

(b) the laws of the state or country where it was executed; or

(c) the laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

(2) If a document of gift is valid under this section, the law of this state governs the interpretation of the document of gift.

(3) A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

Section 260. Section **26B-8-319**, which is renumbered from Section 26-28-120 is renumbered and amended to read:

[~~26-28-120~~]. 26B-8-319. Donor registry.

(1) The Department of Public Safety may establish or contract for the establishment of a donor registry.

(2) The Driver License Division of the Department of Public Safety shall cooperate with a person that administers any donor registry that this state establishes, contracts for, or recognizes for the purpose of transferring to the donor registry all relevant information regarding a donor's making, amendment to, or revocation of an anatomical gift.

(3) A donor registry shall:

(a) allow a donor or other person authorized under Section 26-28-104 to include on the donor registry a statement or symbol that the donor has made, amended, or revoked an anatomical gift;

(b) be accessible to a procurement organization to allow it to obtain relevant information on the donor registry to determine, at or near death of the donor or a prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift; and

(c) be accessible for purposes of Subsections (3)(a) and (b) seven days a week on a 24-hour basis.

(4) Personally identifiable information on a donor registry about a donor or prospective donor may not be used or disclosed without the express consent of the donor, prospective donor, or person that made the anatomical gift for any purpose other than to determine, at or near death of the donor or prospective donor, whether the donor or prospective donor has made, amended, or revoked an anatomical gift.

(5) This section does not prohibit any person from creating or maintaining a donor registry that is not established by or under contract with the state. Any such registry shall comply with Subsections (3) and (4).

Section 261. Section **26B-8-320**, which is renumbered from Section 26-28-121 is renumbered and amended to read:

[~~26-28-121~~]. 26B-8-320. Effect of anatomical gift on advance health care directive.

(1) As used in this section:

(a) "Advance health care directive" means a power of attorney for health care or a record signed or authorized by a prospective donor containing the prospective donor's direction concerning a health care decision for the prospective donor.

(b) "Declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor.

(c) "Health care decision" means any decision regarding the health care of the prospective donor.

(2) If a prospective donor has a declaration or advance health care directive and the terms of the declaration or directive and the express or implied terms of a potential anatomical gift are in conflict with regard to the administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy, the prospective donor's attending physician and prospective donor shall confer to resolve the conflict. If the prospective donor is incapable of resolving the conflict, an agent acting under the prospective donor's declaration or directive, or if no declaration or directive exists or the agent is not reasonably available, another person authorized by a law other than this chapter to make a health care decision on behalf of the prospective donor, shall act for the donor to resolve the conflict. The conflict shall be resolved as expeditiously as possible. Information relevant to the resolution of the conflict may be obtained from the appropriate procurement organization and any other person authorized to make an anatomical gift for the prospective donor under Section 26-28-109. Before resolution of the conflict, measures necessary to ensure the medical suitability of the part may not be withheld or withdrawn from the prospective donor if withholding or withdrawing the measures is not contraindicated by appropriate end of life care.

Section 262. Section **26B-8-321**, which is renumbered from Section 26-28-122 is renumbered and amended to read:

[~~26-28-122~~]. 26B-8-321. Cooperation between medical examiner and procurement organization.

(1) A medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

(2) If a medical examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is going to be performed, unless the medical examiner denies recovery in accordance with Section 26-28-123, the medical examiner or designee shall conduct a postmortem examination of the body or the part in a manner and within a period compatible with its preservation for the purposes of the gift.

(3) A part may not be removed from the body of a decedent under the jurisdiction of a medical examiner for transplantation, therapy, research, or education unless the part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This Subsection (3) does not preclude a medical examiner from performing the medicolegal investigation upon the body or parts of a decedent under the jurisdiction of the medical examiner.

Section 263. Section **26B-8-322**, which is renumbered from Section 26-28-123 is renumbered and amended to read:

[~~26-28-123~~]. 26B-8-322. Facilitation of anatomical gift from decedent whose body is under jurisdiction of medical examiner.

(1) Upon request of a procurement organization, a medical examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is under the jurisdiction of the medical examiner. If the decedent's body or part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the

postmortem examination results or other information received from the medical examiner only if relevant to transplantation or therapy.

(2) The medical examiner may conduct a medicolegal examination by reviewing all medical records, laboratory test results, x-rays, other diagnostic results, and other information that any person possesses about a donor or prospective donor whose body is under the jurisdiction of the medical examiner which the medical examiner determines may be relevant to the investigation.

(3) A person that has any information requested by a medical examiner pursuant to Subsection (2) shall provide that information as expeditiously as possible to allow the medical examiner to conduct the medicolegal investigation within a period compatible with the preservation of parts for the purpose of transplantation, therapy, research, or education.

(4) If an anatomical gift has been or might be made of a part of a decedent whose body is under the jurisdiction of the medical examiner and a postmortem examination is not required, or the medical examiner determines that a postmortem examination is required but that the recovery of the part that is the subject of an anatomical gift will not interfere with the examination, the medical examiner and procurement organization shall cooperate in the timely removal of the part from the decedent for the purpose of transplantation, therapy, research, or education.

(5) If an anatomical gift of a part from the decedent under the jurisdiction of the medical examiner has been or might be made, but the medical examiner initially believes that the recovery of the part could interfere with the postmortem investigation into the decedent's cause or manner of death, the medical examiner shall consult with the procurement organization or physician or technician designated by the procurement organization about the proposed recovery. After consultation, the medical examiner may allow the recovery.

(6) Following the consultation under Subsection (5), in the absence of mutually agreed upon protocols to resolve conflict between the medical examiner and the procurement organization, if the medical examiner intends to deny recovery, the medical examiner or designee, at the request of the procurement organization, may attend the removal procedure for the part before making a final determination not to allow the procurement organization to recover the part. During the removal procedure, the medical examiner or designee may allow recovery by the procurement organization to proceed, or, if the medical examiner or designee

reasonably believes that the part may be involved in determining the decedent's cause or manner of death, deny recovery by the procurement organization.

(7) If the medical examiner or designee denies recovery under Subsection (6), the medical examiner or designee shall:

(a) explain in a record the specific reasons for not allowing recovery of the part;

(b) include the specific reasons in the records of the medical examiner; and

(c) provide a record with the specific reasons to the procurement organization.

(8) If the medical examiner or designee allows recovery of a part under Subsection (4), (5), or (6), the procurement organization, upon request, shall cause the physician or technician who removes the part to provide the medical examiner with a record describing the condition of the part, a biopsy, a photograph, and any other information and observations that would assist in the postmortem examination.

(9) If a medical examiner or designee is required to be present at a removal procedure under Subsection (6), upon request the procurement organization requesting the recovery of the part shall reimburse the medical examiner or designee for the additional costs incurred in complying with Subsection (6).

Section 264. Section **26B-8-323**, which is renumbered from Section 26-28-124 is renumbered and amended to read:

[~~26-28-124~~]. 26B-8-323. Uniformity of application and construction.

In applying and construing [~~this~~] the uniform act in this part, consideration shall be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

Section 265. Section **26B-8-324**, which is renumbered from Section 26-28-125 is renumbered and amended to read:

[~~26-28-125~~]. 26B-8-324. Relation to Electronic Signatures in Global and National Commerce Act.

This act modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001 et seq., but does not modify, limit or supersede Section 101(a) of that act, 15 U.S.C. Section 7001, or authorize electronic delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. Section 7003(b).

Section 266. Section **26B-8-401**, which is renumbered from Section 26-3-1 is

renumbered and amended to read:

Part 4. Health Statistics

[~~26-3-1~~]. 26B-8-401. Definitions.

As used in this [~~chapter~~] part:

(1) "Disclosure" or "disclose" means the communication of health data to any individual or organization outside the department.

(2) "Health data" means any information, except vital records as defined in Section [~~26-2-2~~] 26B-8-101, relating to the health status of individuals, the availability of health resources and services, and the use and cost of these resources and services.

(3) "Identifiable health data" means any item, collection, or grouping of health data which makes the individual supplying it or described in it identifiable.

(4) "Individual" means a natural person.

(5) "Organization" means any corporation, association, partnership, agency, department, unit, or other legally constituted institution or entity, or part of any of these.

(6) "Research and statistical purposes" means the performance of activities relating to health data, including:

(a) describing the group characteristics of individuals or organizations;

(b) analyzing the interrelationships among the various characteristics of individuals or organizations;

(c) the conduct of statistical procedures or studies to improve the quality of health data;

(d) the design of sample surveys and the selection of samples of individuals or organizations;

(e) the preparation and publication of reports describing these matters; and

(f) other related functions.

Section 267. Section **26B-8-402**, which is renumbered from Section 26-3-2 is renumbered and amended to read:

[~~26-3-2~~]. 26B-8-402. Powers of department to collect and maintain health data.

The department may on a voluntary basis, except when there is specific legal authority to compel reporting of health data:

(1) collect and maintain health data on:

(a) the extent, nature, and impact of illness and disability on the population of the state;

(b) the determinants of health and health hazards;

(c) health resources, including the extent of available manpower and resources;

(d) utilization of health care;

(e) health care costs and financing; or

(f) other health or health-related matters;

(2) undertake and support research, demonstrations, and evaluations respecting new or improved methods for obtaining current data on the matters referred to in Subsection (1) of this section;

(3) collect health data under other authorities and on behalf of other governmental or not-for-profit organizations.

Section 268. Section **26B-8-403**, which is renumbered from Section 26-3-4 is renumbered and amended to read:

[~~26-3-4~~]. 26B-8-403. Quality and publication of statistics.

The department shall:

(1) take such actions as may be necessary to assure that statistics developed under this [~~chapter~~] part are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed; and

(2) publish, make available, and disseminate such statistics on as wide a basis as practicable.

Section 269. Section **26B-8-404**, which is renumbered from Section 26-3-5 is renumbered and amended to read:

[~~26-3-5~~]. 26B-8-404. Coordination of health data collection activities.

(1) The department shall coordinate health data activities within the state to eliminate unnecessary duplication of data collection and maximize the usefulness of data collected.

(2) Except as specifically provided, this [~~chapter~~] part does not independently provide authority for the department to compel the reporting of information.

Section 270. Section **26B-8-405**, which is renumbered from Section 26-3-6 is renumbered and amended to read:

[~~26-3-6~~]. 26B-8-405. Uniform standards -- Powers of department.

The department may:

(1) participate and cooperate with state, local, and federal agencies and other organizations in the design and implementation of uniform standards for the management of health information at the federal, state, and local levels; and

(2) undertake and support research, development, demonstrations, and evaluations that support uniform health information standards.

Section 271. Section **26B-8-406**, which is renumbered from Section 26-3-7 is renumbered and amended to read:

[~~26-3-7~~]. 26B-8-406. Disclosure of health data -- Limitations.

The department may not [~~disclose~~] make a disclosure of any identifiable health data unless:

(1) one of the following persons has consented to the disclosure:

(a) the individual;

(b) the next-of-kin if the individual is deceased;

(c) the parent or legal guardian if the individual is a minor or mentally incompetent; or

(d) a person holding a power of attorney covering such matters on behalf of the individual;

(2) the disclosure is to a governmental entity in this or another state or the federal government, provided that:

(a) the data will be used for a purpose for which they were collected by the department; and

(b) the recipient enters into a written agreement satisfactory to the department agreeing to protect such data in accordance with the requirements of this [~~chapter~~] part and department rule and not permit further disclosure without prior approval of the department;

(3) the disclosure is to an individual or organization, for a specified period, solely for bona fide research and statistical purposes, determined in accordance with department rules, and the department determines that the data are required for the research and statistical purposes proposed and the requesting individual or organization enters into a written agreement satisfactory to the department to protect the data in accordance with this [~~chapter~~] part and department rule and not permit further disclosure without prior approval of the department;

(4) the disclosure is to a governmental entity for the purpose of conducting an audit,

evaluation, or investigation of the department and such governmental entity agrees not to use those data for making any determination affecting the rights, benefits, or entitlements of any individual to whom the health data relates;

(5) the disclosure is of specific medical or epidemiological information to authorized personnel within the department, local health departments, public health authorities, official health agencies in other states, the United States Public Health Service, the Centers for Disease Control and Prevention (CDC), or agencies responsible to enforce quarantine, when necessary to continue patient services or to undertake public health efforts to control communicable, infectious, acute, chronic, or any other disease or health hazard that the department considers to be dangerous or important or that may affect the public health;

(6) (a) the disclosure is of specific medical or epidemiological information to a "health care provider" as defined in Section 78B-3-403, health care personnel, or public health personnel who has a legitimate need to have access to the information in order to assist the patient or to protect the health of others closely associated with the patient; and

(b) this Subsection (6) does not create a duty to warn third parties;

(7) the disclosure is necessary to obtain payment from an insurer or other third-party payor in order for the department to obtain payment or to coordinate benefits for a patient; or

(8) the disclosure is to the subject of the identifiable health data.

Section 272. Section **26B-8-407**, which is renumbered from Section 26-3-8 is renumbered and amended to read:

[~~26-3-8~~]. 26B-8-407. Disclosure of health data -- Discretion of department.

(1) Any disclosure provided for in Section 26-3-7 shall be made at the discretion of the department[~~, except that the~~].

(2) Notwithstanding Subsection (1), the disclosure provided for in Subsection [~~26-3-7~~] 26B-8-206(4) shall be made when the requirements of that paragraph are met.

Section 273. Section **26B-8-408**, which is renumbered from Section 26-3-9 is renumbered and amended to read:

[~~26-3-9~~]. 26B-8-408. Health data not subject to subpoena or compulsory process -- Exception.

Identifiable health data obtained in the course of activities undertaken or supported under this [~~chapter~~] part may not be subject to discovery, subpoena, or similar compulsory

process in any civil or criminal, judicial, administrative, or legislative proceeding, nor shall any individual or organization with lawful access to identifiable health data under the provisions of this [~~chapter~~] part be compelled to testify with regard to such health data, except that data pertaining to a party in litigation may be subject to subpoena or similar compulsory process in an action brought by or on behalf of such individual to enforce any liability arising under this [~~chapter~~] part.

Section 274. Section **26B-8-409**, which is renumbered from Section 26-3-10 is renumbered and amended to read:

[~~26-3-10~~]. 26B-8-409. Department measures to protect security of health data.

The department shall protect the security of identifiable health data by use of the following measures and any other measures adopted by rule:

(1) limit access to identifiable health data to authorized individuals who have received training in the handling of such data;

(2) designate a person to be responsible for physical security;

(3) develop and implement a system for monitoring security; and

(4) review periodically all identifiable health data to determine whether identifying characteristics should be removed from the data.

Section 275. Section **26B-8-410**, which is renumbered from Section 26-3-11 is renumbered and amended to read:

[~~26-3-11~~]. 26B-8-410. Relation to other provisions.

Because [~~Chapter 2, Utah Vital Statistics Act, Chapter 4, Utah Medical Examiner Act, Chapter 6, Utah Communicable Disease Control Act, and Chapter 33a, Utah Health Data Authority Act~~] the following parts contain specific provisions regarding collection and disclosure of data, the provisions of this chapter do not apply to data subject to those chapters[~~.~~]:

(1) Chapter 8, Part 1, Vital Statistics;

(2) Chapter 1, Part X, Utah Medical Examiner; and

(3) Chapter 6, Part 5, Utah Health Data Authority.

Section 276. Section **26B-8-411**, which is renumbered from Section 26-1-37 is renumbered and amended to read:

[~~26-1-37~~]. 26B-8-411. Duty to establish standards for the electronic exchange

of clinical health information -- Immunity.

(1) [~~For purposes of~~] As used in this section:

(a) "Affiliate" means an organization that directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with another organization.

(b) "Clinical health information" shall be defined by the department by administrative rule adopted in accordance with Subsection (2).

(c) "Electronic exchange":

(i) includes:

(A) the electronic transmission of clinical health data via Internet or extranet; and

(B) physically moving clinical health information from one location to another using magnetic tape, disk, or compact disc media; and

(ii) does not include exchange of information by telephone or fax.

(d) "Health care provider" means a licensing classification that is either:

(i) licensed under Title 58, Occupations and Professions, to provide health care; or

(ii) licensed under [~~Chapter 21~~] Chapter 2, Part 2, Health Care Facility Licensing and Inspection [~~Act~~].

(e) "Health care system" shall include:

(i) affiliated health care providers;

(ii) affiliated third party payers; and

(iii) other arrangement between organizations or providers as described by the department by administrative rule.

(f) "Qualified network" means an entity that:

(i) is a non-profit organization;

(ii) is accredited by the Electronic Healthcare Network Accreditation Commission, or another national accrediting organization recognized by the department; and

(iii) performs the electronic exchange of clinical health information among multiple health care providers not under common control, multiple third party payers not under common control, the department, and local health departments.

(g) "Third party payer" means:

(i) all insurers offering health insurance who are subject to Section 31A-22-614.5; and

(ii) the state Medicaid program.

(2) (a) [~~In addition to the duties listed in Section 26-1-30, the~~] The department shall, make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(i) define:

(A) "clinical health information" subject to this section; and

(B) "health system arrangements between providers or organizations" as described in Subsection (1)(e)(iii); and

(ii) adopt standards for the electronic exchange of clinical health information between health care providers and third party payers that are for treatment, payment, health care operations, or public health reporting, as provided for in 45 C.F.R. Parts 160, 162, and 164, Health Insurance Reform: Security Standards.

(b) The department shall coordinate its rule making authority under the provisions of this section with the rule making authority of the Insurance Department under Section 31A-22-614.5.

(c) The department shall establish procedures for developing the rules adopted under this section, which ensure that the Insurance Department is given the opportunity to comment on proposed rules.

(3) (a) Except as provided in Subsection (3)(e), a health care provider or third party payer in Utah is required to use the standards adopted by the department under the provisions of Subsection (2) if the health care provider or third party payer elects to engage in an electronic exchange of clinical health information with another health care provider or third party payer.

(b) A health care provider or third party payer may [~~disclose~~] make a disclosure of information to the department or a local health department, by electronic exchange of clinical health information, as permitted by Subsection 45 C.F.R. Sec. 164.512(b).

(c) When functioning in its capacity as a health care provider or payer, the department or a local health department may [~~disclose~~] make a disclosure of clinical health information by electronic exchange to another health care provider or third party payer.

(d) An electronic exchange of clinical health information by a health care provider, a third party payer, the department, a local health department, or a qualified network is a disclosure for treatment, payment, or health care operations if it complies with Subsection

(3)(a) or (c) and is for treatment, payment, or health care operations, as those terms are defined in 45 C.F.R. Parts 160, 162, and 164. (e) A health care provider or third party payer is not required to use the standards adopted by the department under the provisions of Subsection (2) if the health care provider or third party payer engage in the electronic exchange of clinical health information within a particular health care system.

(4) Nothing in this section shall limit the number of networks eligible to engage in the electronic data interchange of clinical health information using the standards adopted by the department under Subsection (2)(a)(ii).

(5) (a) The department, a local health department, a health care provider, a third party payer, or a qualified network is not subject to civil liability for a disclosure of clinical health information if the disclosure is in accordance with:

(i) Subsection (3)(a); and

(ii) Subsection (3)(b), (c), or (d).

(b) The department, a local health department, a health care provider, a third party payer, or a qualified network that accesses or reviews clinical health information from or through the electronic exchange in accordance with the requirements in this section is not subject to civil liability for the access or review.

(6) Within a qualified network, information generated or [~~disclosed~~] for which a disclosure is made in the electronic exchange of clinical health information is not subject to discovery, use, or receipt in evidence in any legal proceeding of any kind or character.

Section 277. Section **26B-8-501**, which is renumbered from Section 26-33a-102 is renumbered and amended to read:

Part 5. Utah Health Data Authority

[~~26-33a-102~~]. 26B-8-501. Definitions.

As used in this [~~chapter~~] part:

(1) "Committee" means the Health Data Committee created [~~by Section 26B-1-204~~] in Section 26B-1-4XX.

(2) "Control number" means a number assigned by the committee to an individual's health data as an identifier so that the health data can be disclosed or used in research and statistical analysis without readily identifying the individual.

(3) "Data supplier" means a health care facility, health care provider, self-funded

employer, third-party payor, health maintenance organization, or government department which could reasonably be expected to provide health data under this [~~chapter~~] part.

(4) "Disclosure" or "disclose" means the communication of health care data to any individual or organization outside the committee, its staff, and contracting agencies.

(5) (a) "Health care facility" means a facility that is licensed by the department under [~~Title 26, Chapter 21~~] Chapter 2, Part 2, Health Care Facility Licensing and Inspection [~~Act~~].

(b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the committee, with the concurrence of the department, may by rule add, delete, or modify the list of facilities that come within this definition for purposes of this [~~chapter~~] part.

(6) "Health care provider" means [~~any person, partnership, association, corporation, or other facility or institution that renders or causes to be rendered health care or professional services as a physician, physician assistant, registered nurse, licensed practical nurse, nurse-midwife, dentist, dental hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, podiatric physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist, speech pathologist, certified social worker, social service worker, social service aide, marriage and family counselor, or practitioner of obstetrics, and others rendering similar care and services relating to or arising out of the health needs of persons or groups of persons, and officers, employees, or agents of any of the above acting in the course and scope of their employment~~] the same as that term is defined in Section 78B-3-403.

(7) "Health data" means information relating to the health status of individuals, health services delivered, the availability of health manpower and facilities, and the use and costs of resources and services to the consumer, except vital records as defined in Section [~~26-2-2~~] 26B-8-101 shall be excluded.

(8) "Health maintenance organization" [~~has the meaning set forth~~] means the same as that term is defined in Section 31A-8-101.

(9) "Identifiable health data" means any item, collection, or grouping of health data that makes the individual supplying or described in the health data identifiable.

(10) "Organization" means any corporation, association, partnership, agency, department, unit, or other legally constituted institution or entity, or part thereof.

(11) "Research and statistical analysis" means activities using health data analysis

including:

(a) describing the group characteristics of individuals or organizations;

(b) analyzing the noncompliance among the various characteristics of individuals or organizations;

(c) conducting statistical procedures or studies to improve the quality of health data;

(d) designing sample surveys and selecting samples of individuals or organizations; and

(e) preparing and publishing reports describing these matters.

(12) "Self-funded employer" means an employer who provides for the payment of health care services for employees directly from the employer's funds, thereby assuming the financial risks rather than passing them on to an outside insurer through premium payments.

(13) "Plan" means the plan developed and adopted by the Health Data Committee under Section [~~26-33a-104~~] 26B-1-XXX.

(14) "Third party payor" means:

(a) an insurer offering a health benefit plan, as defined by Section 31A-1-301, to at least 2,500 enrollees in the state;

(b) a nonprofit health service insurance corporation licensed under Title 31A, Chapter 7, Nonprofit Health Service Insurance Corporations;

(c) a program funded or administered by Utah for the provision of health care services, including the Medicaid and medical assistance programs described in Chapter 18, Medical Assistance Act; and

(d) a corporation, organization, association, entity, or person:

(i) which administers or offers a health benefit plan to at least 2,500 enrollees in the state; and

(ii) which is required by administrative rule adopted by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to supply health data to the committee.

Section 278. Section **26B-8-502**, which is renumbered from Section 26-33a-105 is renumbered and amended to read:

[~~26-33a-105~~]. 26B-8-502. Executive secretary -- Appointment -- Powers.

(1) An executive secretary shall be appointed by the executive director, with the

approval of the committee, and shall serve under the administrative direction of the executive director.

(2) The executive secretary shall:

(a) employ full-time employees necessary to carry out this [~~chapter~~] part;

(b) supervise the development of a draft health data plan for the committee's review, modification, and approval; and

(c) supervise and conduct the staff functions of the committee in order to assist the committee in meeting its responsibilities under this [~~chapter~~] part.

Section 279. Section **26B-8-503**, which is renumbered from Section 26-33a-106 is renumbered and amended to read:

[~~26-33a-106~~]. 26B-8-503. Limitations on use of health data.

The committee may not use the health data provided to it by third-party payors, health care providers, or health care facilities to make recommendations with regard to a single health care provider or health care facility, or a group of health care providers or health care facilities.

Section 280. Section **26B-8-504**, which is renumbered from Section 26-33a-106.1 is renumbered and amended to read:

[~~26-33a-106.1~~]. 26B-8-504. Health care cost and reimbursement data.

(1) The committee shall, as funding is available:

(a) establish a plan for collecting data from data suppliers to determine measurements of cost and reimbursements for risk-adjusted episodes of health care;

(b) share data regarding insurance claims and an individual's and small employer group's health risk factor and characteristics of insurance arrangements that affect claims and usage with the Insurance Department, only to the extent necessary for:

(i) risk adjusting; and

(ii) the review and analysis of health insurers' premiums and rate filings; and

(c) assist the Legislature and the public with awareness of, and the promotion of, transparency in the health care market by reporting on:

(i) geographic variances in medical care and costs as demonstrated by data available to the committee; and

(ii) rate and price increases by health care providers:

(A) that exceed the Consumer Price Index - Medical as provided by the United States

Bureau of Labor Statistics;

(B) as calculated yearly from June to June; and

(C) as demonstrated by data available to the committee;

(d) provide on at least a monthly basis, enrollment data collected by the committee to a not-for-profit, broad-based coalition of state health care insurers and health care providers that are involved in the standardized electronic exchange of health data as described in Section 31A-22-614.5, to the extent necessary:

(i) for the department or the Medicaid Office of the Inspector General to determine insurance enrollment of an individual for the purpose of determining Medicaid third party liability;

(ii) for an insurer that is a data supplier, to determine insurance enrollment of an individual for the purpose of coordination of health care benefits; and

(iii) for a health care provider, to determine insurance enrollment for a patient for the purpose of claims submission by the health care provider;

(e) coordinate with the State Emergency Medical Services Committee to publish data regarding air ambulance charges under Section [~~26-8a-203~~] 26B-1-XXX;

(f) share data collected under this [~~chapter~~] part with the state auditor for use in the health care price transparency tool described in Section 67-3-11; and

(g) publish annually a report on primary care spending within Utah.

(2) (a) The Medicaid Office of Inspector General shall annually report to the Legislature's Health and Human Services Interim Committee regarding how the office used the data obtained under Subsection (1)(d)(i) and the results of obtaining the data.

(b) A data supplier is not liable for a breach of or unlawful disclosure of the data caused by an entity that obtains data in accordance with Subsection (1).

(3) The plan adopted under Subsection (1) shall include:

(a) the type of data that will be collected;

(b) how the data will be evaluated;

(c) how the data will be used;

(d) the extent to which, and how the data will be protected; and

(e) who will have access to the data.

Section 281. Section **26B-8-505**, which is renumbered from Section 26-33a-106.5 is

renumbered and amended to read:

[~~26-33a-106.5~~]. 26B-8-505. Comparative analyses.

(1) The committee may publish compilations or reports that compare and identify health care providers or data suppliers from the data it collects under this [~~chapter~~] part or from any other source.

(2) (a) Except as provided in Subsection (7)(c), the committee shall publish compilations or reports from the data it collects under this [~~chapter~~] part or from any other source which:

(i) contain the information described in Subsection (2)(b); and

(ii) compare and identify by name at least a majority of the health care facilities, health care plans, and institutions in the state.

(b) Except as provided in Subsection (7)(c), the report required by this Subsection (2) shall:

(i) be published at least annually;

(ii) list, as determined by the committee, the median paid amount for at least the top 50 medical procedures performed in the state by volume;

(iii) describe the methodology approved by the committee to determine the amounts described in Subsection (2)(b)(ii); and

(iv) contain comparisons based on at least the following factors:

(A) nationally or other generally recognized quality standards;

(B) charges; and

(C) nationally recognized patient safety standards.

(3) (a) The committee may contract with a private, independent analyst to evaluate the standard comparative reports of the committee that identify, compare, or rank the performance of data suppliers by name.

(b) The evaluation described in this Subsection (3) shall include a validation of statistical methodologies, limitations, appropriateness of use, and comparisons using standard health services research practice.

(c) The independent analyst described in Subsection (3)(a) shall be experienced in analyzing large databases from multiple data suppliers and in evaluating health care issues of cost, quality, and access.

(d) The results of the analyst's evaluation shall be released to the public before the standard comparative analysis upon which it is based may be published by the committee.

(4) [~~In~~] The committee, with the concurrence of the department, shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, [~~the committee, with the concurrence of the department, shall adopt by rule~~] to adopt a timetable for the collection and analysis of data from multiple types of data suppliers.

(5) The comparative analysis required under Subsection (2) shall be available free of charge and easily accessible to the public.

(6) (a) The department shall include in the report required by Subsection (2)(b), or include in a separate report, comparative information on commonly recognized or generally agreed upon measures of cost and quality identified in accordance with Subsection (7), for:

(i) routine and preventive care; and

(ii) the treatment of diabetes, heart disease, and other illnesses or conditions as determined by the committee.

(b) The comparative information required by Subsection (6)(a) shall be based on data collected under Subsection (2) and clinical data that may be available to the committee, and shall compare:

(i) results for health care facilities or institutions;

(ii) results for health care providers by geographic regions of the state;

(iii) a clinic's aggregate results for a physician who practices at a clinic with five or more physicians; and

(iv) a geographic region's aggregate results for a physician who practices at a clinic with less than five physicians, unless the physician requests physician-level data to be published on a clinic level.

(c) The department:

(i) may publish information required by this Subsection (6) directly or through one or more nonprofit, community-based health data organizations; and

(ii) may use a private, independent analyst under Subsection (3)(a) in preparing the report required by this section.

(d) A report published by the department under this Subsection (6):

(i) is subject to the requirements of Section [~~26-33a-107~~] 26B-8-306; and

(ii) shall, prior to being published by the department, be submitted to a neutral, non-biased entity with a broad base of support from health care payers and health care providers in accordance with Subsection (7) for the purpose of validating the report.

(7) (a) The Health Data Committee shall, through the department, for purposes of Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral, non-biased entity with a broad base of support from health care payers and health care providers.

(b) If the entity described in Subsection (7)(a) does not submit the quality measures, the department may select the appropriate number of quality measures for purposes of the report required by Subsection (6).

(c) (i) For purposes of the reports published on or after July 1, 2014, the department may not compare individual facilities or clinics as described in Subsections (6)(b)(i) through (iv) if the department determines that the data available to the department can not be appropriately validated, does not represent nationally recognized measures, does not reflect the mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing providers.

(ii) The department shall report to the Legislature's Health and Human Services Interim Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).

Section 282. Section **26B-8-506**, which is renumbered from Section 26-33a-107 is renumbered and amended to read:

[~~26-33a-107~~]. 26B-8-506. Limitations on release of reports.

The committee may not release a compilation or report that compares and identifies health care providers or data suppliers unless it:

(1) allows the data supplier and the health care provider to verify the accuracy of the information submitted to the committee and submit to the committee any corrections of errors with supporting evidence and comments within a reasonable period of time to be established by rule, with the concurrence of the department, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(2) corrects data found to be in error; and

(3) allows the data supplier a reasonable amount of time prior to publication to review the committee's interpretation of the data and prepare a response.

Section 283. Section **26B-8-507**, which is renumbered from Section 26-33a-108 is renumbered and amended to read:

[~~26-33a-108~~]. 26B-8-507. Disclosure of identifiable health data prohibited.

(1) (a) All information, reports, statements, memoranda, or other data received by the committee are strictly confidential.

(b) Any use, release, or publication of the information shall be done in such a way that no person is identifiable except as provided in Sections [~~26-33a-107~~] 26B-6-306 and [~~26-33a-109~~] 26B-6-308.

(2) No member of the committee may be held civilly liable by reason of having released or published reports or compilations of data supplied to the committee, so long as the publication or release is in accordance with the requirements of Subsection (1).

(3) No person, corporation, or entity may be held civilly liable for having provided data to the committee in accordance with this [~~chapter~~] part.

Section 284. Section **26B-8-508**, which is renumbered from Section 26-33a-109 is renumbered and amended to read:

[~~26-33a-109~~]. 26B-8-508. Exceptions to prohibition on disclosure of identifiable health data.

(1) The committee may not disclose any identifiable health data unless:

(a) the individual has authorized the disclosure;

(b) the disclosure is to the department or a public health authority in accordance with Subsection (2); or

(c) the disclosure complies with the provisions of:

(i) Subsection (3);

(ii) insurance enrollment and coordination of benefits under Subsection [~~26-33a-106.1~~] 26B-8-304(1)(d); or

(iii) risk adjusting under Subsection [~~26-33a-106.1~~] 26B-8-304(1)(b).

(2) The committee may disclose identifiable health data to the department or a public health authority under Subsection (1)(b) if:

(a) the department or the public health authority has clear statutory authority to possess the identifiable health data; and

(b) the disclosure is solely for use:

(i) in the Utah Statewide Immunization Information System operated by the department;

(ii) in the Utah Cancer Registry operated by the University of Utah, in collaboration with the department; or

(iii) by the medical examiner, as defined in Section [~~26-4-2~~] 26B-X-XXX, or the medical examiner's designee.

(3) The committee shall consider the following when responding to a request for disclosure of information that may include identifiable health data:

(a) whether the request comes from a person after that person has received approval to do the specific research or statistical work from an institutional review board; and

(b) whether the requesting entity complies with the provisions of Subsection (4).

(4) A request for disclosure of information that may include identifiable health data shall:

(a) be for a specified period; or

(b) be solely for bona fide research or statistical purposes as determined in accordance with administrative rules adopted by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which shall require:

(i) the requesting entity to demonstrate to the department that the data is required for the research or statistical purposes proposed by the requesting entity; and

(ii) the requesting entity to enter into a written agreement satisfactory to the department to protect the data in accordance with this [~~chapter~~] part or other applicable law.

(5) A person accessing identifiable health data pursuant to Subsection (4) may not further disclose the identifiable health data:

(a) without prior approval of the department; and

(b) unless the identifiable health data is disclosed or identified by control number only.

(6) Identifiable health data that has been designated by a data supplier as being subject to regulation under 42 C.F.R. Part 2, Confidentiality of Substance Use Disorder Patient Records, may only be used or disclosed in accordance with applicable federal regulations.

Section 285. Section **26B-8-509**, which is renumbered from Section 26-33a-110 is renumbered and amended to read:

[~~26-33a-110~~]. 26B-8-509. Penalties.

(1) Any use, release, or publication of health care data contrary to the provisions of Sections [~~26-33a-108~~] 26B-8-307 and [~~26-33a-109~~] 26B-8-308 is a class A misdemeanor.

(2) Subsection (1) does not relieve the person or organization responsible for that use, release, or publication from civil liability.

Section 286. Section **26B-8-510**, which is renumbered from Section 26-33a-111 is renumbered and amended to read:

[~~26-33a-111~~]. 26B-8-510. Health data not subject to subpoena or compulsory process -- Exception.

Identifiable health data obtained in the course of activities undertaken or supported under this [~~chapter~~] part are not subject to subpoena or similar compulsory process in any civil or criminal, judicial, administrative, or legislative proceeding, nor shall any individual or organization with lawful access to identifiable health data under the provisions of this [~~chapter~~] part be compelled to testify with regard to such health data, except that data pertaining to a party in litigation may be subject to subpoena or similar compulsory process in an action brought by or on behalf of such individual to enforce any liability arising under this [~~chapter~~] part.

Section 287. Section **26B-8-511**, which is renumbered from Section 26-33a-115 is renumbered and amended to read:

[~~26-33a-115~~]. 26B-8-511. Consumer-focused health care delivery and payment reform demonstration project.

(1) The Legislature finds that:

(a) current health care delivery and payment systems do not provide system wide incentives for the competitive delivery and pricing of health care services to consumers;

(b) there is a compelling state interest to encourage consumers to seek high quality, low cost care and educate themselves about health care options;

(c) some health care providers and health care payers have developed consumer-focused ideas for health care delivery and payment system reform, but lack the critical number of patient lives and payer involvement to accomplish system-wide consumer-focused reform; and

(d) there is a compelling state interest to encourage as many health care providers and health care payers to join together and coordinate efforts at consumer-focused health care

delivery and payment reform that would provide to consumers enrolled in a high-deductible health plan:

(i) greater choice in health care options;

(ii) improved services through competition; and

(iii) more affordable options for care.

(2) (a) The department shall meet with health care providers and health care payers for the purpose of coordinating a demonstration project for consumer-based health care delivery and payment reform.

(b) Participation in the coordination efforts is voluntary, but encouraged.

(3) The department, in order to facilitate the coordination of a demonstration project for consumer-based health care delivery and payment reform, shall convene and consult with pertinent entities including:

(a) the Utah Insurance Department;

(b) the Office of Consumer Health Services;

(c) the Utah Medical Association;

(d) the Utah Hospital Association; and

(e) neutral, non-biased third parties with an established record for broad based, multi-provider and multi-payer quality assurance efforts and data collection.

(4) The department shall supervise the efforts by entities under Subsection (3) regarding:

(a) applying for and obtaining grant funding and other financial assistance that may be available for demonstrating consumer-based improvements to health care delivery and payment;

(b) obtaining and analyzing information and data related to current health system utilization and costs to consumers; and

(c) consulting with those health care providers and health care payers who elect to participate in the consumer-based health delivery and payment demonstration project.

[~~(5) The executive director shall report to the Health System Reform Task Force by January 1, 2015, regarding the progress toward coordination of consumer-focused health care system payment and delivery reform.~~]

Section 288. Section **26B-8-512**, which is renumbered from Section 26-33a-116 is

renumbered and amended to read:

[~~26-33a-116~~]. 26B-8-512. Health care billing data.

(1) Subject to Subsection (2), the department shall make aggregate data produced under this [~~chapter~~] part available to the public through a standardized application program interface format.

(2) (a) The department shall ensure that data made available to the public under Subsection (1):

(i) does not contain identifiable health data of a patient; and

(ii) meets state and federal data privacy requirements, including the requirements of Section [~~26-33a-107~~] 26B-8-306.

(b) The department may not release any data under Subsection (1) that may be identifiable health data of a patient.

Section 289. Section **26B-8-513**, which is renumbered from Section 26-33a-117 is renumbered and amended to read:

[~~26-33a-117~~]. 26B-8-513. Identifying potential overuse of non-evidence-based health care.

(1) The department shall, in accordance with Title 63G, Chapter 6a, Utah Procurement Code, contract with an entity to provide a nationally-recognized health waste calculator that:

(a) uses principles such as the principles of the Choosing Wisely initiative of the American Board of Internal Medicine Foundation; and

(b) is approved by the committee.

(2) The department shall use the calculator described in Subsection (1) to:

(a) analyze the data in the state's All Payer Claims Database; and

(b) flag data entries that the calculator identifies as potential overuse of non-evidence-based health care.

(3) The department, or a third party organization that the department contracts with in accordance with Title 63G, Chapter 6a, Utah Procurement Code, shall:

(a) analyze the data described in Subsection (2)(b);

(b) review current scientific literature about medical services that are best practice;

(c) review current scientific literature about eliminating duplication in health care;

(d) solicit input from Utah health care providers, health systems, insurers, and other

stakeholders regarding duplicative health care quality initiatives and instances of non-alignment in metrics used to measure health care quality that are required by different health systems;

(e) solicit input from Utah health care providers, health systems, insurers, and other stakeholders on methods to avoid overuse of non-evidence-based health care; and

(f) present the results of the analysis, research, and input described in Subsections (3)(a) through (e) to the committee.

(4) The committee shall:

(a) make recommendations for action and opportunities for improvement based on the results described in Subsection (3)(f);

(b) make recommendations on methods to bring into alignment the various health care quality metrics different entities in the state use; and

(c) identify priority issues and recommendations to include in an annual report.

(5) The department, or the third party organization described in Subsection (3) shall:

(a) compile the report described in Subsection (4)(c); and

(b) submit the report to the committee for approval.

(6) Beginning in 2021, on or before November 1 each year, the department shall submit the report approved in Subsection (5)(b) to the Health and Human Services Interim Committee.

Section 290. Section **26B-8-514**, which is renumbered from Section 26-70-102 is renumbered and amended to read:

[~~26-70-102~~]. 26B-8-514. Standard health record access form.

(1) As used in this section:

(a) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

(b) "Patient" means the individual whose information is being requested.

(c) "Personal representative" means an individual described in 45 C.F.R. Sec. 164.502(g).

[~~(1)~~] (2) Before December 31, 2022, the department shall create a standard form that:

(a) is compliant with HIPAA and 42 C.F.R. Part 2; and

(b) a patient or a patient's personal representative may use to request that a copy of the

patient's health records be sent to any of the following:

(i) the patient;

(ii) the patient's personal representative;

(iii) the patient's attorney; or

(iv) a third party authorized by the patient.

[~~(2)~~] (3) The form described in Subsection (2) shall include fields for:

(a) the patient's name;

(b) the patient's date of birth;

(c) the patient's phone number;

(d) the patient's address;

(e) (i) the patient's signature and date of signature, which may not require notarization; or

(ii) the signature of the patient's personal representative and date of signature, which may not require notarization;

(f) the name, address, and phone number of the person to which the information will be disclosed;

(g) the records requested, including whether the patient is requesting paper or electronic records;

(h) the duration of time the authorization is valid; and

(i) the dates of service requested.

[~~(3)~~] (4) The form described in Subsection (2) shall include the following options for the field described in Subsection [~~(2)~~] (3)(g):

(a) history and physical examination records;

(b) treatment plans;

(c) emergency room records;

(d) radiology and lab reports;

(e) operative reports;

(f) pathology reports;

(g) consultations;

(h) discharge summary;

(i) outpatient clinic records and progress notes;

(j) behavioral health evaluation;

(k) behavioral health discharge summary;

(l) mental health therapy records;

(m) financial information including an itemized billing statement;

(n) health insurance claim form;

(o) billing form; and

(p) other.