Title 26. Utah Health Code

Chapter 1
Department of Health Organization

26-1-1 Title cited as "Utah Health Code."

This title shall be known and may be cited as the "Utah Health Code."

Enacted by Chapter 126, 1981 General Session

26-1-2 Definitions.

Subject to additional definitions contained in the chapters of this title which are applicable to specific chapters, as used in this title:

(1) "Council" means the Utah Health Advisory Council.

(2) "Department" means the Department of Health created in Section 26-1-4.

(3) "Executive director" means the executive director of the department appointed pursuant to Section 26-1-8.

(4) "Public health authority" means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, an Indian tribe, or a person acting under a grant of authority from or contract with such an agency, that is responsible for public health matters as part of its official mandate.

Amended by Chapter 391, 2012 General Session

26-1-3 Purpose of title -- Consolidation of health functions into single state agency.

The purpose of this title is to consolidate into a single agency of state government certain health functions exercised by the Department of Human Services including those performed by the Division of Health, the Board of Health, the Office of Health Care Financing and Standards, the State Health Planning Development Agency, the Nursing Home Advisory Council, the Health Facilities Council, and similar affiliated agencies, in order to more efficiently and effectively manage health programs that are the responsibility of the state, to establish a health policy for the state and to promote health, the quality of life, and contain costs in the health field.

Amended by Chapter 112, 1991 General Session

26-1-4 Department of Health created -- Policymaking responsibilities -- Consultation with local health departments -- Committee to evaluate health policies and to review federal grants -- Committee responsibilities.

(1) There is created the Department of Health, which has all of the policymaking functions, regulatory and enforcement powers, rights, duties, and responsibilities of the Division of Health, the Board of Health, the State Health Planning Development Agency, and the Office of Health Care Financing. Unless otherwise specifically provided, when reference is made in any statute of this state to the Board of Health, the Division of Health, the State Health Planning Development Agency, or the Office of Health Care Financing, it refers to the department. The department shall assume all of the policymaking functions, powers, rights, duties, and responsibilities over the division, agency, and office previously vested in the Department of Human Services and its executive director.

(2) In establishing public health policy, the department shall consult with the local health departments established under Title 26A, Chapter 1, Local Health Departments.

(3)

(a) As used in this Subsection (3):

(i) "Committee" means the committee established under Subsection (3)(b).

(ii) "Exempt application" means an application for a federal grant that meets the criteria established under Subsection (3)(c)(iii).

(iii) "Expedited application" means an application for a federal grant that meets the criteria established under Subsection (3)(c)(iv).

(iv) "Federal grant" means a grant from the federal government that could provide funds for local health departments to help them fulfill their duties and responsibilities.

(v) "Reviewable application" means an application for a federal grant that is not an exempt application.

(b) The department shall establish a committee consisting of:

(i) the executive director, or the executive director's designee;

(ii) two representatives of the department, appointed by the executive director; and

(iii) three representatives of local health departments, appointed by all local health departments.

(c) The committee shall:

(i) evaluate:

(A) the allocation of public health resources between the department and local health departments; and

(B) policies that affect local health departments;

(ii) consider policy changes proposed by the department or local health departments;

(iii) establish criteria by which an application for a federal grant may be judged to determine whether it should be exempt from the requirements under Subsection (3)(d); and

(iv) establish criteria by which an application for a federal grant may be judged to determine whether committee review under Subsection (3)(d)(i) should be delayed until after the application is submitted because the application is required to be submitted under a timetable that makes committee review before it is submitted impracticable if the submission deadline is to be met.

(d)

(i) The committee shall review the goals and budget for each reviewable application:

(A) before the application is submitted, except for an expedited application; and

(B) for an expedited application, after the application is submitted but before funds from the federal grant for which the application was submitted are disbursed or encumbered.

(ii) Funds from a federal grant pursuant to a reviewable application may not be disbursed or encumbered before the goals and budget for the federal grant are established by:

(A) a two-thirds vote of the committee, following the committee review under Subsection (3)(d)(i); or

(B) if two-thirds of the committee cannot agree on the goals and budget, the chair of the health advisory council, after consultation with the committee in a manner that the committee determines.

(e) An exempt application is exempt from the requirements of Subsection (3)(d).

(f) The department may use money from a federal grant to pay administrative costs incurred in implementing this Subsection (3).

Amended by Chapter 167, 2013 General Session

26-1-4.1 Department procedures -- Adjudicative proceedings.

The Department of Health shall comply with the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act, in its adjudicative proceedings.

Amended by Chapter 382, 2008 General Session

26-1-5 Rules of department.

(1)

(a) Except in areas subject to concurrence between the department and a committee created under this title , the department shall have the power to adopt, amend, or rescind rules necessary to carry out the provisions of this title.

(b) If the adoption of rules under a provision of this title is subject to concurrence between the department and a committee created under this title and no concurrence can be reached, the department has final authority to adopt, amend, or rescind rules necessary to carry out the provisions of this title.

(c) When the provisions of this title require concurrence between the department and a committee created under this title:

(i) the department shall report to and update the committee on a regular basis related to matters requiring concurrence; and

(ii) the committee shall review the report submitted by the department under this Subsection (1)(c) and shall:

(A) concur with the report; or

(B) provide a reason for not concurring with the report and provide an alternative recommendation to the department.

(2) Rules shall have the force and effect of law and may deal with matters which materially affect the security of health or the preservation and improvement of public health in the state, and any matters as to which jurisdiction is conferred upon the department by this title.

(3) Every rule adopted by the department, or by the concurrence of the department and a committee established under Section 26-1-7 or 26-1-7.5, shall be subject to Title 63G, Chapter 3, Utah Administrative Rulemaking Act and shall become effective at the time and in the manner provided in that act.

(4) If, at the next general session of the Legislature following the filing of a rule with the legislative research director, the Legislature passes a bill disapproving such rule, the rule shall be null and void.

(5) The department or the department in concurrence with a committee created under Section 26-1-7 or 26-1-7.5, may not adopt a rule identical to a rule disapproved under Subsection (4) of this section before the beginning of the next general session of the Legislature following the general session at which the rule was disapproved.

Amended by Chapter 74, 2016 General Session

26-1-6 Fee schedule adopted by department.

(1) The department may adopt a schedule of fees that may be assessed for services rendered by the department, provided that the fees are:

(a) reasonable and fair; and

(b) submitted to the Legislature as part of the department's annual appropriations request.

(2) When the department submits a fee schedule to the Legislature, the Legislature, in accordance with Section 63J-1-504, may:

(a) approve the fee;
(b) increase or decrease and approve the fee; or
(c) reject any fee submitted to it.
(3) Fees approved by the Legislature pursuant to this section shall be paid into the state treasury.

Amended by Chapter 469, 2018 General Session

26-1-7 Committees within department.
(1) There are created within the department the following committees:
(a) Health Facility Committee;
(b) State Emergency Medical Services Committee;
(c) Air Ambulance Committee;
(d) Health Data Committee;
(e) Utah Health Care Workforce Financial Assistance Program Advisory Committee;
(f) Residential Child Care Licensing Advisory Committee;
(g) Child Care Center Licensing Committee; and
(h) Primary Care Grant Committee.
(2) The department shall:
(a) consolidate advisory groups and committees with other committees or advisory groups as appropriate to create greater efficiencies and budgetary savings for the department; and
(b) create in writing, time-limited and subject-limited duties for the advisory groups or committees as necessary to carry out the responsibilities of the department.

Amended by Chapter 419, 2017 General Session

26-1-7.1 Committee procedures -- Adjudicative proceedings.
All committees created by Section 26-1-7 shall comply with the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act, in their adjudicative proceedings.

Amended by Chapter 382, 2008 General Session

26-1-7.5 Health advisory council.
(1)
(a) There is created the Utah Health Advisory Council, comprised of nine persons appointed by the governor.
(b) The governor shall ensure that:
(i) members of the council:
(A) broadly represent the public interest;
(B) have an interest in or knowledge of public health, environmental health, health planning, health care financing, or health care delivery systems; and
(C) include health professionals;
(ii) the majority of the membership are nonhealth professionals;
(iii) no more than five persons are from the same political party; and
(iv) geography, sex, and ethnicity balance are considered when selecting the members.
(2)
(a) Except as required by Subsection (2)(b), members of the council shall be appointed to four-year terms.

(b) Notwithstanding the requirements of Subsection (2)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of council members are staggered so that approximately half of the council is appointed every two years.
(c) Terms of office for subsequent appointments shall commence on July 1 of the year in which the appointment occurs.
(3)
(a) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.
(b) No person shall be appointed to the council for more than two consecutive terms.
(c) The chair of the council shall be appointed by the governor from the membership of the council.
(4) The council shall meet at least quarterly or more frequently as determined necessary by the chair. A quorum for conducting business shall consist of four members of the council.
(5) A member may not receive compensation or benefits for the member's service, but, at the executive director's discretion, 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.
(6) The council shall be empowered to advise the department on any subject deemed to be appropriate by the council except that the council may not become involved in administrative matters. The council shall also advise the department as requested by the executive director.
(7) The executive director shall ensure that the council has adequate staff support and shall provide any available information requested by the council necessary for their deliberations. The council shall observe confidential requirements placed on the department in the use of such information.

Amended by Chapter 297, 2011 General Session

26-1-8 Executive director -- Appointment -- Compensation.

The chief administrative officer of the department is the executive director who shall be appointed by the governor with the consent of the Senate. The executive director shall serve at the pleasure of the governor. The governor shall establish the executive director's salary within the salary range fixed by the Legislature in Title 67, Chapter 22, State Officer Compensation.

Amended by Chapter 176, 2002 General Session

26-1-9 Executive director -- Qualifications.

(1) Except as provided in Subsection (2), the executive director shall be a physician who is a graduate of a regularly chartered and legally constituted medical school, licensed to practice medicine and surgery in all branches in the state, who has successfully completed:
(a) a master's degree of public health from an accredited school of public health or from an accredited program of public health and has at least three years professional full-time experience in a senior level administrative capacity; or
(b) at least one year's graduate work in an accredited school of public health and has at least five years professional full-time experience, of which at least three years have been in public health in a senior level administrative capacity.
(2) If the executive director is not a physician under Subsection (1), the executive director shall:

(a)
(i) have successfully completed at least a master's degree of public health or public administration from an accredited school of public health or from an accredited program of public health or public administration; and
(ii) have at least five years of professional full-time experience, of which at least two years have been in public health in a senior level administrative capacity; or
(b) have at least seven years of professional full-time experience in public health programs, of which at least five years have been in a senior level administrative capacity.
(3) An executive director shall be thoroughly informed and experienced in all aspects of public health work.
(4) If the executive director is not a physician, the deputy director of the department shall be a physician who has successfully completed at least one year's graduate work in an accredited school of public health or an accredited program of public health.

Amended by Chapter 141, 2011 General Session

26-1-10 Executive director -- Enforcement powers.

The executive director is empowered to issue orders to enforce state laws and rules established by the department except where the enforcement power is given to a committee created pursuant to Section 26-1-7.

Enacted by Chapter 126, 1981 General Session

26-1-11 Executive director -- Power to amend, modify, or rescind committee rules.

The executive director pursuant to the requirements of the Administrative Rulemaking Act may amend, modify, or rescind any rule of any committee created pursuant to Section 26-1-7 if the rule creates a clear present hazard or clear potential hazard to the public health except that the executive director may not act until after discussion with the appropriate committee.

Amended by Chapter 297, 2011 General Session

26-1-12 Executive director -- Power to order abatement of public health hazard.

If the executive director finds that a condition of filth, sanitation, or other health hazard exists which creates a clear present hazard to the public health and which requires immediate action to protect human health or safety, the executive director with the concurrence of the governor may order persons causing or contributing to the condition to reduce, discontinue, or ameliorate it to the extent that the public health hazard is eliminated.

Amended by Chapter 112, 1991 General Session

26-1-13 Executive director -- Power to organize department.

The executive director shall organize the department into divisions and offices and shall structure such organization to promote the efficiency and effectiveness of the operations of the department.

Enacted by Chapter 126, 1981 General Session

26-1-14 Executive director -- Appointment, removal, and compensation of division directors.

The executive director shall have administrative jurisdiction over the directors of the divisions and offices established under Section 26-1-13. Each director shall be appointed by the executive director and may be removed at the will of the executive director. The directors shall be compensated in an amount fixed by the executive director. The division directors shall be experienced in administration and have knowledge and be familiar with their areas of responsibility.

Amended by Chapter 169, 1988 General Session

26-1-15 Executive director -- Power to accept federal aid.

The executive director with the approval of the governor may accept, in behalf of the state, and bind the state by such acceptance, any executive or legislative provisions promulgated or enacted by the federal government or any agency thereof, whereby the state is invited, permitted, or authorized 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. All applications for federal grants or assistance in support of any department program shall be approved by the executive director. If any executive or legislative provisions of the federal government shall require, as a condition to participation by the state in any fund, property, or service, the executive director, with the governor's approval shall expend whatever funds are necessary out of money appropriated by the legislature for use and disbursement by the department.

Enacted by Chapter 126, 1981 General Session

26-1-16 Executive director -- Power to accept funds and gifts.

The executive director may accept and receive such other funds and gifts as may be made available from private and public groups for the purposes of promoting and protecting the public health or for the provision of health services to the people of the state and shall expend the same as appropriated by the legislature.

Enacted by Chapter 126, 1981 General Session

26-1-17 Executive director -- Power to prescribe rules for administration and government of department.

The executive director shall prescribe rules not inconsistent with law for the administration and government of the department, the conduct of its employees and the custody, use and preservation of the records, papers, books, documents, and property of the department.

Enacted by Chapter 126, 1981 General Session

26-1-17.1 Background checks for employees.

(1) As used in this section, "bureau" means the Bureau of Criminal Identification created in Section 53-10-201.

(2) Beginning July 1, 2018, the department may require a fingerprint-based local, regional, and national criminal history background check and ongoing monitoring of:

(a) all staff, contracted employees, and volunteers who:

(i) have access to protected health information or personal identifying information;

(ii) have direct contact with patients, children, or vulnerable adults as defined in Section 62A-2-120;

(iii) work in areas of privacy and data security;
(iv) handle financial information, including receipt of funds, reviewing invoices, making payments, and other types of financial information; and
(v) perform audit functions, whether internal or external, on behalf of the department; and
(b) job applicants who have been offered a position with the department and the job requirements include those described in Subsection (2)(a).
(3) Each individual in a position listed in Subsection (2) shall provide a completed fingerprint card to the department upon request.
(4) The department shall require that an individual required to submit to a background check under Subsection (3) provide a signed waiver on a form provided by the department that meets the requirements of Subsection 53-10-108(4).
(5) For a noncriminal justice background search and registration in accordance with Subsection 53-10-108(13), the department shall submit to the bureau:
(a) the applicant's personal identifying information and fingerprints for a criminal history search of applicable local, regional, and national databases; and
(b) a request for all information received as a result of the local, regional, and nationwide background check.
(6) The department is responsible for the payment of all fees required by Subsection 53-10-108(15) and any fees required to be submitted to the Federal Bureau of Investigation by the bureau.
(7) The department may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that:
(a) determine how the department will assess the employment status of an individual upon receipt of background information;
(b) determine the type of crimes and the severity that would disqualify an individual from holding a position; and
(c) identify the appropriate privacy risk mitigation strategy to be used in accordance with Subsection 53-10-108(13)(b).

Enacted by Chapter 427, 2018 General Session

26-1-17.5 Confidential records.
(1) A record classified as confidential under this title shall remain confidential, and be released according to the provisions of this title, notwithstanding Section 63G-2-310.
(2) In addition to those persons granted access to a private record described in Subsection 63G-2-302(1)(b), schools, school districts, and local and state health departments and the state Department of Human Services may share an immunization record as defined in Section 53G-9-301 or any other record relating to a vaccination or immunization as necessary to ensure compliance with Title 53G, Chapter 8, Part 3, Physical Restraint of Students, and to prevent, investigate, and control the causes of epidemic, infectious, communicable, and other diseases affecting the public health.

Amended by Chapter 415, 2018 General Session

26-1-18 Authority of department generally.
The department is the health, health planning, and medical assistance authority of the state and is the sole state agency for administration of federally assisted state programs or plans for

public health, health planning, maternal and child health, services for children with a disability, and medical assistance.

Amended by Chapter 366, 2011 General Session

26-1-20 Advisory committees created by department.

The department may create such advisory committees as it deems necessary to assist in carrying out the provisions of this title.

Enacted by Chapter 126, 1981 General Session

26-1-21 Disposal of property by department.

(1) The department may dispose of any personal property owned by it or any of the entities created under Section 26-1-13, in the manner provided in Title 63A, Chapter 2, Part 4, Surplus Property Service.
(2) The department may dispose of any real property owned by it or any of the entities created under Section 26-1-13, in the manner provided in Title 65A, Chapter 4, Acquisition and Disposition of Land by State Agencies.

Amended by Chapter 207, 2011 General Session

26-1-22 Budget preparation and submission to governor.

The department shall prepare and submit to the governor a proposed budget to be included in the budget submitted by the governor to the legislature for the fiscal year following the convening of the legislature.

Enacted by Chapter 126, 1981 General Session

26-1-23 Regulations for local health departments prescribed by department -- Local standards not more stringent than federal or state standards -- Exceptions for written findings.

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may prescribe by rule reasonable requirements not inconsistent with law for a local health department as defined in Section 26A-1-102.
(2) Except as provided in Subsection (3), or where specifically allowed by federal law or state statute, a local health department, as defined in Section 26A-1-102, may not establish standards or regulations that are more stringent than those established by federal law, state statute, or administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(3)
  (a) The local health department may make standards and regulations more stringent than corresponding federal law, state statute, or state administrative rules, only if the local health department makes a written finding after public comment and hearing and based on evidence in the record, that corresponding federal laws, state statutes, or state administrative rules are not adequate to protect public health of the state.
  (b) The findings shall address the public health information and studies contained in the record, which form the basis for the local health department's conclusion.

(4) Nothing in the provisions of Subsection (2) or (3), shall limit the ability of a local health department to make standards and regulations in accordance with Subsection 26A-1-121(1)(a) for:
(a) emergency rules made in accordance with Section 63G-3-304; or
(b) items not regulated under federal law, state statute, or state administrative rule.

Amended by Chapter 307, 2012 General Session

26-1-23.5 Rules for sale of drugs, cosmetics, and medical devices.
The department shall establish and enforce rules for the sale or distribution of human drugs, cosmetics, and medical devices. The rules adopted under this section shall be no more stringent than those established by federal law.

Renumbered and Amended by Chapter 112, 1991 General Session

26-1-24 Hearings conducted by department.
The department may hold hearings, administer oaths, subpoena witnesses, and take testimony in matters relating to the exercise and performance of the powers and duties vested in or imposed upon the department. The department may, at its sole discretion, contract with any other agency or department of the state to conduct hearings in the name of the department.

Enacted by Chapter 126, 1981 General Session

26-1-25 Principal and branch offices of department.
The principal office of the department shall be in Salt Lake County. The department may establish branch offices at other places in the state to furnish comprehensive and effective health programs and to render additional assistance to local health officials. This section does not limit the powers of local health agencies.

Amended by Chapter 297, 2011 General Session

26-1-26 Director of community health nursing appointed by executive director.
There shall be within the department a director of community health nursing appointed by the executive director who shall develop, implement, monitor, and evaluate community health nursing standards and services and participate in the formulation of policies for administration of health services.

Enacted by Chapter 126, 1981 General Session

26-1-30 Powers and duties of department.
The department shall exercise the following powers and duties, in addition to other powers and duties established in this chapter:
(1) enter into cooperative agreements with the Department of Environmental Quality to delineate specific responsibilities to assure that assessment and management of risk to human health from the environment are properly administered;
(2) consult with the Department of Environmental Quality and enter into cooperative agreements, as needed, to ensure efficient use of resources and effective response to potential health and

safety threats from the environment, and to prevent gaps in protection from potential risks from the environment to specific individuals or population groups;
(3) promote and protect the health and wellness of the people within the state;
(4) establish, maintain, and enforce rules necessary or desirable to carry out the provisions and purposes of this title to promote and protect the public health or to prevent disease and illness;
(5) investigate and control the causes of epidemic, infectious, communicable, and other diseases affecting the public health;
(6) provide for the detection, reporting, prevention, and control of communicable, infectious, acute, chronic, or any other disease or health hazard which the department considers to be dangerous, important, or likely to affect the public health;
(7) collect and report information on causes of injury, sickness, death, and disability and the risk factors that contribute to the causes of injury, sickness, death, and disability within the state;
(8) collect, prepare, publish, and disseminate information to inform the public concerning the health and wellness of the population, specific hazards, and risks that may affect the health and wellness of the population and specific activities which may promote and protect the health and wellness of the population;
(9) establish and operate programs necessary or desirable for the promotion or protection of the public health and the control of disease or which may be necessary to ameliorate the major causes of injury, sickness, death, and disability in the state, except that the programs may not be established if adequate programs exist in the private sector;
(10) establish, maintain, and enforce isolation and quarantine, and for this purpose only, exercise physical control over property and individuals as the department finds necessary for the protection of the public health;
(11) close theaters, schools, and other public places and forbid gatherings of people when necessary to protect the public health;
(12) abate nuisances when necessary to eliminate sources of filth and infectious and communicable diseases affecting the public health;
(13) make necessary sanitary and health investigations and inspections in cooperation with local health departments as to any matters affecting the public health;
(14) establish laboratory services necessary to support public health programs and medical services in the state;
(15) establish and enforce standards for laboratory services which are provided by any laboratory in the state when the purpose of the services is to protect the public health;
(16) cooperate with the Labor Commission to conduct studies of occupational health hazards and occupational diseases arising in and out of employment in industry, and make recommendations for elimination or reduction of the hazards;
(17) cooperate with the local health departments, the Department of Corrections, the Administrative Office of the Courts, the Division of Juvenile Justice Services, and the Crime Victim Reparations Board to conduct testing for HIV infection of alleged sexual offenders, convicted sexual offenders, and any victims of a sexual offense;
(18) investigate the causes of maternal and infant mortality;
(19) establish, maintain, and enforce a procedure requiring the blood of adult pedestrians and drivers of motor vehicles killed in highway accidents be examined for the presence and concentration of alcohol;
(20) provide the Commissioner of Public Safety with monthly statistics reflecting the results of the examinations provided for in Subsection (19) and provide safeguards so that information derived from the examinations is not used for a purpose other than the compilation of statistics authorized in this Subsection (20);

(21) establish qualifications for individuals permitted to draw blood pursuant to Subsection 41-6a-523(1)(a)(vi), 53-10-405(2)(a)(vi), 72-10-502(5)(a)(vi), or 77-23-213(3)(a)(vi), and to issue permits to individuals it finds qualified, which permits may be terminated or revoked by the department;
(22) establish a uniform public health program throughout the state which includes continuous service, employment of qualified employees, and a basic program of disease control, vital and health statistics, sanitation, public health nursing, and other preventive health programs necessary or desirable for the protection of public health;
(23) adopt rules and enforce minimum sanitary standards for the operation and maintenance of:
(a) orphanages;
(b) boarding homes;
(c) summer camps for children;
(d) lodging houses;
(e) hotels;
(f) restaurants and all other places where food is handled for commercial purposes, sold, or served to the public;
(g) tourist and trailer camps;
(h) service stations;
(i) public conveyances and stations;
(j) public and private schools;
(k) factories;
(l) private sanatoria;
(m) barber shops;
(n) beauty shops;
(o) physician offices;
(p) dentist offices;
(q) workshops;
(r) industrial, labor, or construction camps;
(s) recreational resorts and camps;
(t) swimming pools, public baths, and bathing beaches;
(u) state, county, or municipal institutions, including hospitals and other buildings, centers, and places used for public gatherings; and
(v) any other facilities in public buildings or on public grounds;
(24) conduct health planning for the state;
(25) monitor the costs of health care in the state and foster price competition in the health care delivery system;
(26) adopt rules for the licensure of health facilities within the state pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;
(27) license the provision of child care;
(28) accept contributions to and administer the funds contained in the Organ Donation Contribution Fund created in Section 26-18b-101;
(29) serve as the collecting agent, on behalf of the state, for the nursing care facility assessment fee imposed under Title 26, Chapter 35a, Nursing Care Facility Assessment Act, and adopt rules for the enforcement and administration of the nursing facility assessment consistent with the provisions of Title 26, Chapter 35a, Nursing Care Facility Assessment Act;
(30) establish methods or measures for health care providers, public health entities, and health care insurers to coordinate among themselves to verify the identity of the individuals they serve;
(31)

(a) designate Alzheimer's disease and related dementia as a public health issue and, within budgetary limitations, implement a state plan for Alzheimer's disease and related dementia by incorporating the plan into the department's strategic planning and budgetary process; and
(b) coordinate with other state agencies and other organizations to implement the state plan for Alzheimer's disease and related dementia;
(32) ensure that any training or certification required of a public official or public employee, as those terms are defined in Section 63G-22-102, complies with Title 63G, Chapter 22, State Training and Certification Requirements, if the training or certification is required:
(a) under this title;
(b) by the department; or
(c) by an agency or division within the department; and
(33) oversee public education vision screening as described in Section 53G-9-404.

Amended by Chapter 87, 2019 General Session

26-1-32 Severability of code provisions.

If any provision of this code or the application of any such provision to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this code which can be given effect without the invalid provision or application, and to this end the provisions of this code are declared to be severable.

Amended by Chapter 297, 2011 General Session

26-1-33 Individual rights protected.

Nothing in this title shall prohibit an individual from choosing the diet, therapy, or mode of treatment to be administered to an individual or an individual's family.

Enacted by Chapter 126, 1981 General Session

26-1-34 Restricted account created to fund drug testing for law enforcement agencies.

(1) There is created within the General Fund a restricted account known as the State Laboratory Drug Testing Account.
(2) The account consists of a specified portion of fees generated under Subsection 53-3-106(5) from the reinstatement of certain licenses, which shall be deposited in this account.
(3) The Department of Health shall use funds in this account solely for the costs of performing drug and alcohol analysis tests for state and local law enforcement agencies, and may not assess any charge or fee to the law enforcement agencies for whom the analysis tests are performed.

Enacted by Chapter 247, 1998 General Session

26-1-35 Content and form of certificates and reports.

(1) Certificates, certifications, forms, reports, other documents and records, and the form of communication between persons required by this title shall be prepared in the form prescribed by department rule.
(2) Certificates, certifications, forms, reports, or other documents and records, and communications between persons required by this title may be signed, filed, verified, registered, and stored by photographic, electronic, or other means as prescribed by department rule.

Enacted by Chapter 86, 2000 General Session

26-1-36 Duty to establish program to reduce deaths and other harm from prescription opiates used for chronic noncancer pain.

(1) As used in this section, "opiate" means any drug or other substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability.

(2) In addition to the duties listed in Section 26-1-30, the department shall develop and implement a two-year program in coordination with the Division of Professional Licensing, the Utah Labor Commission, and the Utah attorney general, to:

(a) investigate the causes of and risk factors for death and nonfatal complications of prescription opiate use and misuse in Utah for chronic pain by utilizing the Utah Controlled Substance Database created in Section 58-37f-201;

(b) study the risks, warning signs, and solutions to the risks associated with prescription opiate medications for chronic pain, including risks and prevention of misuse and diversion of those medications;

(c) provide education to health care providers, patients, insurers, and the general public on the appropriate management of chronic pain, including the effective use of medical treatment and quality care guidelines that are scientifically based and peer reviewed; and

(d) educate the public regarding:

(i) the purpose of the Controlled Substance Database established in Section 58-37f-201; and

(ii) the requirement that a person's name and prescription information be recorded on the database when the person fills a prescription for a schedule II, III, IV, or V controlled substance.

Amended by Chapter 43, 2013 General Session
Amended by Chapter 167, 2013 General Session

26-1-37 Duty to establish standards for the electronic exchange of clinical health information -- Immunity.

(1) For purposes of 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, 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 department shall, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(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 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 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 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.

Amended by Chapter 105, 2019 General Session

26-1-38 Local health emergency assistance program.
(1) As used in this section:
(a) "Local health department" means the same as that term is defined in Section 26A-1-102.
(b) "Local health emergency" means an unusual event or series of events causing or resulting in a substantial risk or substantial potential risk to the health of a significant portion of the population within the boundary of a local health department, as determined by the local health department.
(c) "Program" means the local health emergency assistance program that the department is required to establish under this section.
(d) "Program fund" means money that the Legislature appropriates to the department for use in the program and other money otherwise made available for use in the program.
(2) The department shall establish, to the extent of funds appropriated by the Legislature or otherwise made available to the program fund, a local health emergency assistance program.
(3) Under the program, the department shall:
(a) provide a method for a local health department to seek reimbursement from the program fund for local health department expenses incurred in responding to a local health emergency;
(b) require matching funds from any local health department seeking reimbursement from the program fund;
(c) establish a method for apportioning money in the program fund to multiple local health departments when the total amount of concurrent requests for reimbursement by multiple local health departments exceeds the balance in the program fund; and
(d) establish by rule other provisions that the department considers necessary or advisable to implement the program.
(4)
(a)
(i) Subject to Subsection (4)(a)(ii), the department shall use money in the program fund exclusively for purposes of the program.
(ii) The department may use money in the program fund to cover its costs of administering the program.

(b) Money that the Legislature appropriates to the program fund is nonlapsing in accordance with Section 63J-1-602.1.
(c) Any interest earned on money in the program fund shall be deposited to the General Fund.

Amended by Chapter 180, 2015 General Session

26-1-40 Reports of anesthesia adverse events -- Whistle blower protections.
(1)
(a) Beginning January 1, 2018, the department shall create a database of deaths and adverse events from the administration of sedation or anesthesia in outpatient settings that are not emergency departments in the state.
(b) The database required by Subsection (1)(a) shall include reports submitted by health care providers under Sections 58-5a-502, 58-31b-502.5, 58-67-502.5, 58-68-502.5, and 58-69-502.5.
(2) The department shall adopt administrative rules under Title 63G, Chapter 3, Utah Administrative Rulemaking Act, regarding:
(a) the format of the reports; and
(b) what constitutes a reportable adverse event, which shall include at least the administration of intravenous sedation or anesthesia when there is:
(i) an escalation of care required for the patient; or
(ii) a rescue of a patient from a deeper level of sedation than was intended.
(3)
(a) Information the department receives under this section that identifies a particular individual is subject to Title 63G, Chapter 2, Government Records Access and Management Act, and the federal Health Insurance Portability and Accountability Act of 1996.
(b) Beginning July 1, 2018, and on or before July 1 of each year thereafter, the department shall:
(i) publicly report:
(A) the number of deaths and adverse events reported under Subsection (1);
(B) the type of health care providers, by license category and specialty, who submitted reports under Subsection (1) and who administered the sedation or anesthesia that resulted in an adverse event; and
(C) the type of facility in which the death or adverse event took place; and
(ii) submit a report to the Health and Human Services Interim Committee with the information required by this Subsection (3).
(4) An employer of a health care provider who submits a report under this section may not take an adverse employment action against the reporting health care provider if the employment action is based on the provider submitting a report under this section.
(5)
(a) This section sunsets in accordance with Section 63I-1-226.
(b) The sunset review of this section shall include an analysis of:
(i) the number and types of adverse events reported under this section;
(ii) the types of health care providers and locations involved in the adverse events;
(iii) the adequacy of sedation and anesthesia requirements in Sections 58-5a-502, 58-31b-502.5, 58-67-502.5, 58-68-502.5, and 58-69-502.5 related to the adverse events reported under this section; and
(iv) the adequacy of the reporting requirements under this section and the need for additional protections for health care providers who report events under this section.

Enacted by Chapter 177, 2017 General Session

Chapter 2
Utah Vital Statistics Act

26-2-1 Short title.

This chapter is known as the "Utah Vital Statistics Act."

Amended by Chapter 202, 1995 General Session

26-2-2 Definitions.

As used in this chapter:

(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) "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.

(3) "Dead body" or "decedent" means a human body or parts of the human body from the condition of which it reasonably may be concluded that death occurred.

(4) "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.

(5) "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.

(6) "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 (6)(a); or

(B) the person described in Subsection (6)(a) is unable or unwilling to exercise the right and duty described in Subsection (6)(a); and

(ii) the next of kin voluntarily acts as the dispositioner.

(7) "File" means the submission of a completed certificate or other similar document, record, or report as provided under this chapter for registration by the state registrar or a local registrar.

(8) "Funeral service director" means the same as that term is defined in Section 58-9-102.

(9) "Health care facility" means the same as that term is defined in Section 26-21-2.

(10) "Health care professional" means a physician, physician assistant, or nurse practitioner.

(11) "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.

(12) "Live birth" means the birth of a child who shows evidence of life after the child is entirely outside of the mother.

(13) "Local registrar" means a person appointed under Subsection 26-2-3(3)(b).

(14) "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.

(15) "Office" means the Office of Vital Records and Statistics within the Department of Health, operating under Title 26, Chapter 2, Utah Vital Statistics Act.

(16) "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.

(17) "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.

(18) "Presumed father" means the father of a child conceived or born during a marriage as defined in Section 30-1-17.2.

(19) "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.

(20) "State registrar" means the state registrar of vital records appointed under Subsection 26-2-3(2)(e).

(21) "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 (21)(a);

(c) an adoption document; and

(d) other similar documents.

(22) "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.

Amended by Chapter 49, 2018 General Session
Amended by Chapter 153, 2018 General Session

26-2-3 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;
(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 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.

Amended by Chapter 22, 2017 General Session

26-2-4 Content and form of certificates and reports.
(1) Except as provided in Subsection (5), 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 or the rules implementing this chapter 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.
(2) Certificates, certifications, forms, reports, other documents and records, and the form of communications between persons required by this chapter shall be prepared in the format prescribed by department rule.
(3) All vital records shall include the date of filing.
(4) Certificates, certifications, forms, reports, other documents and records, and communications between persons required by this chapter may be signed, filed, verified, registered, and stored by photographic, electronic, or other means as prescribed by department rule.
(5) The state:
(a) may collect the Social Security number of a deceased individual; and
(b) may not include the Social Security number of an individual on a certificate of death.

Amended by Chapter 32, 2007 General Session

26-2-5 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.
(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.
(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 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.

Amended by Chapter 349, 2019 General Session

26-2-5.5 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, or other person responsible for completing and filing the birth certificate under Section 26-2-5 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 100-485.

Amended by Chapter 202, 1995 General Session

26-2-6 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.

Amended by Chapter 202, 1995 General Session

26-2-7 Correction of errors or omissions in vital records.

The department may make rules governing applications to correct alleged errors or omissions on any vital record.

Amended by Chapter 202, 1995 General Session

26-2-8 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(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.

Amended by Chapter 202, 1995 General Session

26-2-9 Birth certificates -- Petition for issuance of delayed certificate -- Court procedure.

(1) If registration of a certificate of birth under Section 26-2-8 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. 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. 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) 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. The order shall be registered by the state registrar and constitutes the certificate of birth.

Amended by Chapter 202, 1995 General Session

26-2-10 Supplementary certificate of birth.
(1) Any person born in this state who is legitimized by the subsequent marriage of the person's natural parents, or whose parentage has been determined by any U.S. state court or Canadian provincial court having jurisdiction, or who has been legally adopted under the law of this or any other state or any province of Canada, may request the state registrar to register a supplementary birth certificate on the basis of that status.
(2) The application for registration of a supplementary birth certificate may be made by the person requesting registration, if the person is of legal age, by a legal representative, or by 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 person, 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 provided under Section 78B-6-141 or Section 78B-6-144.

Amended by Chapter 137, 2015 General Session

26-2-11 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.

Amended by Chapter 202, 1995 General Session

26-2-12.5 Certified copies of birth certificates -- Fees credited to Children's Account.

(1) In addition to the fees provided for in Section 26-1-6, 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. This additional fee may be charged only for the first copy requested at any one time.

(2) The fee shall be transmitted monthly to the state treasurer and credited to the Children's Account established in Section 62A-4a-309.

Amended by Chapter 278, 2010 General Session

26-2-12.6 Fee waived for certified copy of birth certificate.

(1) Notwithstanding Section 26-1-6 and Section 26-2-12.5, 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;

(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; or

(iv) 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, as defined in Section 10-9a-526;

(b) a permanent housing, permanent, supportive, or transitional facility, as defined in Section 35A-5-302;

(c) the Department of Workforce Services;

(d) a facility that serves an individual described in Subsection (1)(b) and maintains data on an individual described in Subsection (1)(b) through the Homeless Management Information System; or

(e) a local educational agency liaison for homeless children and youth designated under 42 U.S.C. Sec. 11432(g)(1)(J)(ii).

Amended by Chapter 242, 2019 General Session

26-2-13 Certificate of death -- Execution and registration requirements.

(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.

(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, 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.

(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 30 days after 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, 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.

Amended by Chapter 66, 2009 General Session
Amended by Chapter 68, 2009 General Session

26-2-14 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.
(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, 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.

Amended by Chapter 202, 1995 General Session

26-2-14.1 Certificate of birth resulting in stillbirth.
(1) For purposes of this section and Section 26-2-14.2, "stillbirth" and "stillborn child" shall have the same meaning as "dead fetus" in Section 26-2-2.
(2)
  (a) In addition to the requirements of Section 26-2-14, 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.

Enacted by Chapter 69, 2002 General Session

26-2-14.2 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.

Enacted by Chapter 69, 2002 General Session

26-2-14.3 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.
(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.

Enacted by Chapter 184, 2015 General Session

26-2-15 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(2)(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 it 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 filing of the petition.
(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 he 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.

Amended by Chapter 3, 2008 General Session

26-2-16 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 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.

Amended by Chapter 66, 2009 General Session
Amended by Chapter 68, 2009 General Session

26-2-17 Certificate of death -- Registration prerequisite to interment -- Burial-transit permits -- Procedure where body donated under anatomical gift law -- Permit for disinterment.

(1) 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.
(2) For deaths or fetal deaths which occur in this state, no burial-transit permit is required for final disposition of the remains if:
  (a) disposition occurs in the state and is performed by a funeral service director; or
  (b) the disposition takes place with authorization of the next of kin and in a general acute hospital, as defined in Section 26-21-2, that is licensed by the department, or in a pathology laboratory operated under contract with a general acute hospital licensed by the department.
(3) A burial-transit permit shall be issued by the local registrar of the district where the certificate of death or fetal death is registered:
  (a) for dead bodies or fetuses to be transported out of the state for final disposition; or
  (b) when disposition is made by a person other than a funeral service director.
(4) A burial-transit permit issued under the law of another state which accompanies a dead body or dead fetus brought into this state is authority for final disposition of the dead body or dead fetus 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 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 or dead fetus, except as otherwise provided by statute or department rule.

Amended by Chapter 60, 2007 General Session

26-2-18 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 or dead fetus 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 his 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.

Amended by Chapter 56, 2006 General Session

26-2-18.5 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.

(b) "Unavailable for postmortem investigation" means the same as that term is defined in Section 26-4-2.

(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, 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.

Amended by Chapter 189, 2019 General Session

26-2-19 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.

Amended by Chapter 202, 1995 General Session

26-2-21 Local registrars authorized to issue certified copies of records.

The state registrar may authorize local registrars to issue certified copies of vital records.

Amended by Chapter 202, 1995 General Session

26-2-22 Inspection of vital records.

(1)

(a) The vital records shall be open to inspection, but only in compliance with the provisions of this chapter, 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, 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.

(2) A direct, tangible, and legitimate interest in a vital record is present only if:

(a) the request is from:

(i) the subject;

(ii) a member of the subject's immediate family;

(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 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.

(3) For purposes of Subsection (2):

(a) "immediate family member" means a spouse, child, parent, sibling, grandparent, or grandchild;

(b) a designated legal representative means an attorney, physician, funeral service director, genealogist, or other agent of the subject or the subject's immediate family who has been delegated the authority to access vital records;

(c) except as provided in Title 78B, Chapter 6, Part 1, Utah Adoption Act, a parent, or the 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 pursuant to Title 78A, Chapter 6, Juvenile Court Act of 1996, 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; and

(d) a commercial firm or agency requesting names, addresses, or similar information may not be considered as having a direct, tangible, and legitimate interest.

(4) 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(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 (4)(a) or (b) if 75 years or more have passed since the date of the event upon which the record is based.

(5) 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.

(6) 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 a birth parent's election to permit identifying information about the birth parent to be made available, under Section 78B-6-141;
(b) for the release of information by the mutual-consent, voluntary adoption registry, under Section 78B-6-144; and
(c) for collecting fees and donations pursuant to Section 78B-6-144.5.

Amended by Chapter 137, 2015 General Session

26-2-23 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.
(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.

Amended by Chapter 68, 2009 General Session

26-2-24 Marriage licenses -- Execution and filing requirements.

The state registrar shall supply county clerks with application forms for marriage licenses. Completed applications shall be transmitted by the clerks to the state registrar monthly. 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. The person performing the marriage shall furnish the date and place of marriage and his name and address. The form shall be completed and certified by the county clerk before it is filed with the state registrar.

Amended by Chapter 202, 1995 General Session

26-2-25 Divorce or adoption -- Duty of court clerk to file certificates or reports.

(1)

(a) 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. The petitioner shall provide the information necessary to prepare the certificate or report when he files the petition with the clerk.

(b) The clerk shall prepare the certificate or report and, immediately after the decree or order becomes final, shall complete the remaining entries. On or before the 15th day of each month, the clerk shall forward the divorce certificates and reports of adoption completed by him during the preceding month to the state registrar.

(2) If there is filed with the clerk of the court in an adoption proceeding a written consent to adoption by an agency licensed under the laws of the state to receive children for placement or adoption, the agency by its authorized representative shall prepare and complete the report of adoption and forward it to the state registrar immediately after entry of the decree of adoption.

Amended by Chapter 202, 1995 General Session

26-2-26 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 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.

Amended by Chapter 202, 1995 General Session

26-2-27 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.

Amended by Chapter 366, 2011 General Session

26-2-28 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, the department shall prepare a birth certificate for any person who:
(1) was adopted under the laws of this state; and
(2) was at the time of adoption considered an alien child for whom the court received documentary evidence of legal residence under Section 78B-6-108.

Amended by Chapter 3, 2008 General Session

Chapter 3
Health Statistics

26-3-1 Definitions.

As used in this chapter:
(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, 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.

Amended by Chapter 202, 1995 General Session

26-3-2 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.

Enacted by Chapter 126, 1981 General Session

26-3-4 Quality and publication of statistics.

The department shall:
(1) take such actions as may be necessary to assure that statistics developed under this chapter 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.

Enacted by Chapter 126, 1981 General Session

26-3-5 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 does not independently provide authority for the department to compel the reporting of information.

Amended by Chapter 201, 1996 General Session

26-3-6 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.

Amended by Chapter 201, 1996 General Session

26-3-7 Disclosure of health data -- Limitations.

The department may not disclose 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 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 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.

Amended by Chapter 278, 2013 General Session

26-3-8 Disclosure of health data -- Discretion of department.

Any disclosure provided for in Section 26-3-7 shall be made at the discretion of the department, except that the disclosure provided for in Subsection 26-3-7(4) shall be made when the requirements of that paragraph are met.

Amended by Chapter 297, 2011 General Session

26-3-9 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 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 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.

Amended by Chapter 201, 1996 General Session

26-3-10 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.

Amended by Chapter 201, 1996 General Session

26-3-11 Relation to other chapters.

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 contain specific provisions regarding collection and disclosure of data, the provisions of this chapter do not apply to data subject to those chapters.

Amended by Chapter 243, 2005 General Session

Chapter 4

Utah Medical Examiner Act

26-4-1 Short title.

This chapter shall be known and may be cited as the "Utah Medical Examiner Act."

Enacted by Chapter 126, 1981 General Session

26-4-2 Definitions.

As used in this chapter:

(1) "Dead body" is as defined in Section 26-2-2.

(2) "Death by violence" means death that resulted by the decedent's exposure to physical, mechanical, or chemical forces, and includes death which appears to have been due to homicide, death which 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) "Medical examiner" means the state medical examiner appointed pursuant to Section 26-4-4 or a deputy appointed by the medical examiner.

(5) "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.

(6) "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).

(7) "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.

(8) "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.

(9) "Suicide" means death caused by an intentional and voluntary act of a person who understands the physical nature of the act and intends by such act to accomplish self-destruction.

(10) "Unattended death" means the death of a person who has not been seen by a physician or physician assistant within the scope of the physician's or physician assistant's professional capacity within 30 days immediately prior to the date of death. This definition does not require an investigation, autopsy, or inquest in any case where death occurred without medical attendance solely because the deceased was under treatment by prayer or spiritual means alone in accordance with the tenets and practices of a well-recognized church or religious denomination.

(11)

(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.

(12) "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.

Amended by Chapter 349, 2019 General Session

26-4-4 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.

Amended by Chapter 72, 2015 General Session

26-4-5 County medical examiners.

The county executive, with the advice and consent of the county legislative body, may appoint medical examiners for their respective counties.

Amended by Chapter 227, 1993 General Session

26-4-6 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.

Amended by Chapter 63, 2009 General Session

26-4-7 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 was:

(1) by violence, gunshot, suicide, or accident;
(2) sudden death while in apparent good health;
(3) unattended deaths, except that an autopsy may only be performed in accordance with the provisions of Subsection 26-4-9(3);
(4) under suspicious or unusual circumstances;
(5) resulting from poisoning or overdose of drugs;
(6) resulting from diseases that may constitute a threat to the public health;
(7) resulting from disease, injury, toxic effect, or unusual exertion incurred within the scope of the decedent's employment;
(8) due to sudden infant death syndrome;
(9) resulting 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) associated with diagnostic or therapeutic procedures; or
(11) 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.

Amended by Chapter 183, 2012 General Session

26-4-8 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.

Amended by Chapter 38, 1993 General Session

26-4-9 Custody of dead body and personal effects -- Examination of scene of death -- Preservation of body -- Autopsies.

(1) 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. 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. 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. The body may not be moved without permission of the medical examiner, district attorney, or county attorney having criminal jurisdiction, or his authorized deputy except in cases of affront to public decency or circumstances where it is not practical to leave the body where found, or in such cases where the cause of death is clearly due to natural causes. The body can under direction of a licensed physician or the medical examiner or his designated representative be moved to a place specified by a funeral director, the attending physician, the medical examiner, or his representative.

(2) In the event the body, where referred to the medical examiner, is moved, no cleansing or embalming of the body shall occur without the permission of the medical examiner. An intentional or knowing violation of this Subsection (2) is a class B misdemeanor.

(3) 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, or a licensed physician, or a spouse, child, parent or guardian of the deceased, and a licensed physician. 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. In any such case concerning unattended deaths qualifying as exempt from autopsy, a death certificate may be certified by a licensed physician. In this case the physician may be established as the medical examiner's designated representative. Requested autopsies may not be performed when the medical examiner or the medical examiner's designated representative determines the autopsy to be unnecessary, provided that an autopsy requested by a district or county attorney or law enforcement agency may only be determined to be unnecessary if the cause of death can be ascertained without an autopsy being performed.

Amended by Chapter 297, 2011 General Session

26-4-10 Certification of cause of death.

The certification of the cause of death under any of the circumstances listed in Section 26-4-7 shall only be made by the medical examiner or his designated representative. Certification of the cause of death or signature on the certificate of death by any other person is a class B misdemeanor.

Enacted by Chapter 126, 1981 General Session

26-4-10.5 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 of age 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 Occupational and 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.

Enacted by Chapter 104, 2016 General Session

26-4-11 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.

Amended by Chapter 414, 2018 General Session

26-4-12 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.

Amended by Chapter 297, 2011 General Session

26-4-13 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.

Amended by Chapter 278, 2001 General Session

26-4-14 Certification of death by attending physician or physician assistant -- Deaths without medical attendance -- Cause of death uncertain -- Notice requirements.

The physician or physician assistant in attendance at the last illness of a deceased person who, in the judgment of the physician or physician assistant, does not appear to have died in a manner described in Section 26-4-7, shall certify the cause of death to his best knowledge and belief. When there is no physician or physician assistant in attendance during the last illness

or when an attending physician or physician assistant is unable to determine with reasonable certainty the cause of death, the physician, physician assistant, or person with custody of the body shall so notify the medical examiner. If the medical examiner has reason to believe there may be criminal responsibility for the death, he shall notify the district attorney or county attorney having criminal jurisdiction or the head of the law enforcement agency having jurisdiction to make further investigation of the death.

Amended by Chapter 349, 2019 General Session

26-4-15 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.

Enacted by Chapter 126, 1981 General Session

26-4-16 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.

Amended by Chapter 144, 2007 General Session

26-4-17 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) Upon written request from an individual described in Subsections (2)(a) through (d), 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:
  (a) a decedent's immediate relative;
  (b) a decedent's legal representative;
  (c) a physician or physician assistant who attended the decedent during the year before the decedent's death; or

(d) as necessary for the performance of the individual's professional duties, a county attorney, a district attorney, a criminal defense attorney, or other law enforcement official with jurisdiction.

(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 of Health; and

(d) provides to the medical examiner an approval from:

(i) the researcher's sponsoring organization; and

(ii) the Utah Department of Health 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 26-1-6, 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) Except as provided in this chapter or ordered by a court, the medical examiner may not disclose any part of a medical examiner record.

(8) 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).

Amended by Chapter 349, 2019 General Session

26-4-18 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.

Enacted by Chapter 126, 1981 General Session

26-4-19 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.

Amended by Chapter 38, 1993 General Session

26-4-20 Officials not liable for authorized acts.

Except as provided in this chapter, 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 or for any other act authorized by this chapter.

Amended by Chapter 297, 2011 General Session

26-4-21 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.

Amended by Chapter 372, 1997 General Session

26-4-22 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.

Enacted by Chapter 126, 1981 General Session

26-4-23 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.

Enacted by Chapter 126, 1981 General Session

26-4-24 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.

Amended by Chapter 375, 1997 General Session

26-4-25 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.

Repealed and Re-enacted by Chapter 72, 2015 General Session

26-4-26 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 upon request.

Enacted by Chapter 232, 1997 General Session

26-4-27 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.

Enacted by Chapter 153, 1998 General Session

26-4-28 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).

Amended by Chapter 167, 2013 General Session

26-4-28.5 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.

Enacted by Chapter 346, 2017 General Session

26-4-29 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.

Amended by Chapter 218, 2010 General Session

Chapter 5
Chronic Disease Control

26-5-1 "Chronic disease" defined.

As used in this chapter, "chronic disease" means an impairment or deviation from the normal functioning of the human body having one or more of the following characteristics:
(1) It is permanent;
(2) It leaves residual disability;
(3) It is caused by nonreversible pathological alterations;
(4) It requires special patient education and instruction for rehabilitation;
(5) It may require a long period of supervision, observation and care.

Enacted by Chapter 126, 1981 General Session

26-5-2 Establishment of prevention programs by department.

The department shall establish and operate reasonable programs to prevent, delay, and detect the onset of chronic diseases including cancer, diabetes, cardiovascular and pulmonary diseases, genetic diseases, and such other chronic diseases as the department determines are important in promoting, protecting, and maintaining the public's health.

Enacted by Chapter 126, 1981 General Session

26-5-3 System for detecting and monitoring diseases established by department.

(1) The department shall develop and maintain a system for detecting and monitoring chronic diseases within the state and shall investigate and determine the epidemiology of those conditions which contributed to preventable and premature sickness, or both, and to death and disability.
(2) Beginning July 1, 2004, the department shall consider the disease known as "lupus" a chronic disease subject to the detection and monitoring provisions of Subsection (1).

Amended by Chapter 197, 2004 General Session

26-5-4 Programs of community and professional education established by department.

The department shall establish programs of community and professional education relevant to the detection, prevention and control of chronic diseases.

Enacted by Chapter 126, 1981 General Session

Chapter 6
Utah Communicable Disease Control Act

26-6-1 Short title.

This chapter shall be known and may be cited as the "Utah Communicable Disease Control Act."

Enacted by Chapter 126, 1981 General Session

26-6-2 Definitions.

As used in this chapter:

(1) "Ambulatory surgical center" is as defined in Section 26-21-2.

(2) "Carrier" means an infected individual or animal who harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source of infection for man. The carrier state may occur in an individual with an infection that is inapparent throughout its course, commonly known as healthy or asymptomatic carrier, or during the incubation period, convalescence, and postconvalescence of an individual with a clinically recognizable disease, commonly known as incubatory carrier or convalescent carrier. Under either circumstance the carrier state may be of short duration, as a temporary or transient carrier, or long duration, as a chronic carrier.

(3) "Communicable disease" means illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from a reservoir to a susceptible host, either directly, as from an infected individual or animal, or indirectly, through an intermediate plant or animal host, vector, or the inanimate environment.

(4) "Communicable period" means the time or times during which an infectious agent may be transferred directly or indirectly from an infected individual to another individual, from an infected animal to man, or from an infected man to an animal, including arthropods.

(5) "Contact" means an individual or animal having had association with an infected individual, animal, or contaminated environment so as to have had an opportunity to acquire the infection.

(6) "End stage renal disease facility" is as defined in Section 26-21-2.

(7) "Epidemic" means the occurrence or outbreak in a community or region of cases of an illness clearly in excess of normal expectancy and derived from a common or propagated source. The number of cases indicating an epidemic will vary according to the infectious agent, size, and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence. Epidemicity is considered to be relative to usual frequency of the disease in the same area, among the specified population, at the same season of the year.

(8) "General acute hospital" is as defined in Section 26-21-2.

(9) "Incubation period" means the time interval between exposure to an infectious agent and appearance of the first sign or symptom of the disease in question.

(10) "Infected individual" means an individual who harbors an infectious agent and who has manifest disease or inapparent infection. An infected individual is one from whom the infectious agent can be naturally acquired.

(11) "Infection" means the entry and development or multiplication of an infectious agent in the body of man or animals. Infection is not synonymous with infectious disease; the result may be inapparent or manifest. The presence of living infectious agents on exterior surfaces of the body, or upon articles of apparel or soiled articles, is not infection, but contamination of such surfaces and articles.

(12) "Infectious agent" means an organism such as a virus, rickettsia, bacteria, fungus, protozoan, or helminth that is capable of producing infection or infectious disease.

(13) "Infectious disease" means a disease of man or animals resulting from an infection.

(14) "Isolation" means the separation, for the period of communicability, of infected individuals or animals from others, in such places and under such conditions as to prevent the direct or indirect conveyance of the infectious agent from those infected to those who are susceptible or who may spread the agent to others.

(15) "Quarantine" means the restriction of the activities of well individuals or animals who have been exposed to a communicable disease during its period of communicability to prevent disease transmission.
(16) "School" means a public, private, or parochial nursery school, licensed or unlicensed day care center, child care facility, family care home, headstart program, kindergarten, elementary, or secondary school through grade 12.
(17) "Sexually transmitted disease" means those diseases transmitted through sexual intercourse or any other sexual contact.
(18) "Specialty hospital" is as defined in Section 26-21-2.

Amended by Chapter 150, 2012 General Session

26-6-3 Authority to investigate and control epidemic infections and communicable disease.
(1) The department has authority to investigate and control the causes of epidemic infections and communicable disease, and shall provide for the detection, reporting, prevention, and control of communicable diseases and epidemic infections or any other health hazard which may affect the public health.
(2)
(a) As part of the requirements of Subsection (1), the department shall distribute to the public and to health care professionals:
(i) medically accurate information about sexually transmitted diseases that may cause infertility and sterility if left untreated, including descriptions of:
(A) the probable side effects resulting from an untreated sexually transmitted disease, including infertility and sterility;
(B) medically accepted treatment for sexually transmitted diseases;
(C) the medical risks commonly associated with the medical treatment of sexually transmitted diseases; and
(D) suggested screening by a private physician or physician assistant; and
(ii) information about:
(A) public services and agencies available to assist individuals with obtaining treatment for the sexually transmitted disease;
(B) medical assistance benefits that may be available to the individual with the sexually transmitted disease; and
(C) abstinence before marriage and fidelity after marriage being the surest prevention of sexually transmitted disease.
(b) The information required by Subsection (2)(a):
(i) shall be distributed by the department and by local health departments free of charge;
(ii) shall be relevant to the geographic location in which the information is distributed by:
(A) listing addresses and telephone numbers for public clinics and agencies providing services in the geographic area in which the information is distributed; and
(B) providing the information in English as well as other languages that may be appropriate for the geographic area.
(c)
(i) Except as provided in Subsection (2)(c)(ii), the department shall develop written material that includes the information required by this Subsection (2).
(ii) In addition to the written materials required by Subsection (2)(c)(i), the department may distribute the information required by this Subsection (2) by any other methods the

department determines is appropriate to educate the public, excluding public schools, including websites, toll free telephone numbers, and the media.

(iii) If the information required by Subsection (2)(b)(ii)(A) is not included in the written pamphlet developed by the department, the written material shall include either a website, or a 24-hour toll free telephone number that the public may use to obtain that information.

Amended by Chapter 349, 2019 General Session

26-6-3.5 Reporting AIDS and HIV infection -- Anonymous testing.

(1) Because of the nature and consequences of Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection, the department shall:

(a) require reporting of those conditions; and

(b) utilize contact tracing and other methods for "partner" identification and notification. The department shall, by rule, define individuals who are considered "partners" for purposes of this section.

(2)

(a) The requirements of Subsection (1) do not apply to seroprevalence and other epidemiological studies conducted by the department.

(b) The requirements of Subsection (1) do not apply to, and anonymity shall be provided in, research studies conducted by universities or hospitals, under the authority of institutional review boards if those studies are funded in whole or in part by research grants and if anonymity is required in order to obtain the research grant or to carry out the research.

(3) For all purposes of this chapter, Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus infection are considered communicable and infectious diseases.

(4) The department may establish or allow one site or agency within the state to provide anonymous testing.

(a) The site or agency that provides anonymous testing shall maintain accurate records regarding:

(i) the number of HIV positive individuals that it is able to contact or inform of their condition;

(ii) the number of HIV positive individuals who receive extensive counseling;

(iii) how many HIV positive individuals provide verifiable information for partner notification; and

(iv) how many cases in which partner notification is carried through.

(b) If the information maintained under Subsection (4)(a) indicates anonymous testing is not resulting in partner notification, the department shall phase out the anonymous testing program allowed by this Subsection (4).

Amended by Chapter 116, 2006 General Session

26-6-4 Involuntary examination, treatment, isolation, and quarantine.

(1) The following individuals or groups of individuals are subject to examination, treatment, quarantine, or isolation under a department order of restriction:

(a) an individual who is infected or suspected to be infected with a communicable disease that poses a threat to the public health and who does not take action as required by the department or the local health department to prevent spread of the disease;

(b) an individual who is contaminated or suspected to be contaminated with an infectious agent that poses a threat to the public health and that could be spread to others if remedial action is not taken;

(c) an individual who is in a condition or suspected condition which, if exposed to others, poses a threat to public health, or is in a condition which if treatment is not completed will pose a threat to public health; and
(d) an individual who is contaminated or suspected to be contaminated with a chemical or biological agent that poses a threat to the public health and that could be spread to others if remedial action is not taken.
(2) If an individual refuses to take action as required by the department or the local health department to prevent the spread of a communicable disease, infectious agent, or contamination, the department or the local health department may order involuntary examination, treatment, quarantine, or isolation of the individual and may petition the district court to order involuntary examination, treatment, quarantine, or isolation in accordance with Title 26, Chapter 6b, Communicable Diseases - Treatment, Isolation, and Quarantine Procedures.

Amended by Chapter 185, 2006 General Session

26-6-5 Willful introduction of communicable disease a misdemeanor.

Any person who willfully or knowingly introduces any communicable or infectious disease into any county, municipality, or community is guilty of a class A misdemeanor, except as provided in Section 76-10-1309.

Amended by Chapter 179, 1993 General Session

26-6-6 Duty to report individual suspected of having communicable disease.

The following shall report to the department or the local health department regarding any individual suffering from or suspected of having a disease that is communicable, as required by department rule:
(1) health care providers as defined in Section 78B-3-403;
(2) facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;
(3) health care facilities operated by the federal government;
(4) mental health facilities;
(5) care facilities licensed by the Department of Human Services;
(6) nursing homes and other care facilities;
(7) dispensaries, clinics, or laboratories that diagnose, test, or otherwise care for individuals who are suffering from a disease suspected of being communicable;
(8) individuals who have knowledge of others who have a communicable disease;
(9) individuals in charge of schools having responsibility for any individuals who have a disease suspected of being communicable; and
(10) child care programs, as defined in Section 26-39-102.

Amended by Chapter 3, 2008 General Session

26-6-7 Designation of communicable diseases by department -- Establishment of rules for detection, reporting, investigation, prevention, and control.

The department may designate those diseases which are communicable, of concern to the public health, and reportable; and establish rules for the detection, reporting, investigation, prevention, and control of communicable diseases, epidemic infections, and other health hazards that affect the public health.

Amended by Chapter 211, 1996 General Session

26-6-8 Tuberculosis -- Duty of department to investigate, control, and monitor.

(1) The department shall conduct or oversee the investigation, control, and monitoring of suspected or confirmed tuberculosis infection and disease within the state. Local health departments shall investigate, control, and monitor suspected or confirmed tuberculosis infection and disease within their respective jurisdictions.

(2) A health care provider who treats an individual with suspected or confirmed tuberculosis shall treat the individual according to guidelines established by the department.

Amended by Chapter 211, 1996 General Session

26-6-9 Tuberculosis -- Testing of high risk individuals.

Individuals at high risk for tuberculosis shall be tested as required by department rule. The department rule:

(1) shall establish criteria to identify individuals who are at high risk for tuberculosis; and

(2) may establish who is responsible for the costs of the testing.

Repealed and Re-enacted by Chapter 211, 1996 General Session

26-6-11 Rabies or other animal disease -- Investigation and order of quarantine.

Whenever rabies or any other animal disease dangerous to the health of human beings is reported, the department shall investigate to determine whether such disease exists, and the probable area of the state in which man or beast is thereby endangered. If the department finds that such disease exists, a quarantine may be declared against all animals designated in the quarantine order and within the area specified in the order. If the quarantine is for the purpose of preventing the spread of rabies or hydrophobia, the order shall contain a warning to the owners of dogs within the quarantined area to confine or muzzle all dogs to prevent biting. Any dog not muzzled found running at large in a quarantined area or any dog known to have been removed from or escaped from such area, may be killed by any person without liability therefor.

Enacted by Chapter 126, 1981 General Session

26-6-12 Rabies or other animal disease -- Investigation following order of quarantine.

Following the order of quarantine the department shall make a thorough investigation as to the extent of the disease, the probable number of persons and beasts exposed, and the area involved.

Enacted by Chapter 126, 1981 General Session

26-6-13 Rabies or other animal disease -- Authority of peace officer to kill or capture animals.

During the period any quarantine order is in force all peace officers may kill or capture and hold for further action by the department all animals in a quarantined area not held in restraint on private premises.

Enacted by Chapter 126, 1981 General Session

26-6-14 Rabies or other animal disease -- Quarantine defined.

Quarantine for the purposes of Sections 26-6-11 through 26-6-13 means strict confinement upon the private premises of the owners, under restraint by leash, closed cage or paddock of all animals specified by the order.

Enacted by Chapter 126, 1981 General Session

26-6-15 Rabies or other animal disease -- Possession of animal in violation of chapter a misdemeanor.

Any person in possession of any animal being held in violation of this chapter is guilty of a class C misdemeanor.

Enacted by Chapter 126, 1981 General Session

26-6-16 Venereal diseases declared dangerous to public health.

Syphilis, gonorrhea, lymphogranuloma inguinale (venereum) and chancroid are hereby declared to be contagious, infectious, communicable and dangerous to the public health.

Enacted by Chapter 126, 1981 General Session

26-6-17 Venereal disease -- Examinations by authorities -- Treatment of infected persons.

State, county, and municipal health officers within their respective jurisdictions may make examinations of persons reasonably suspected of being infected with venereal disease. Persons infected with venereal disease shall be required to report for treatment to either a reputable physician or physician assistant and continue treatment until cured or to submit to treatment provided at public expense until cured.

Amended by Chapter 349, 2019 General Session

26-6-18 Venereal disease -- Consent of minor to treatment.

(1) A consent to medical care or services by a hospital or public clinic or the performance of medical care or services by a licensed physician or physician assistant executed by a minor who is or professes to be afflicted with a sexually transmitted disease, shall have the same legal effect upon the minor and the same legal obligations with regard to the giving of consent as a consent given by a person of full legal age and capacity, the infancy of the minor and any contrary provision of law notwithstanding.
(2) The consent of the minor is not subject to later disaffirmance by reason of minority at the time it was given and the consent of no other person or persons shall be necessary to authorize hospital or clinical care or services to be provided to the minor by a licensed physician or physician assistant.
(3) The provisions of this section shall apply also to minors who profess to be in need of hospital or clinical care and services or medical care or services provided by a physician or physician assistant for suspected sexually transmitted disease, regardless of whether such professed suspicions are subsequently substantiated on a medical basis.

Amended by Chapter 349, 2019 General Session

26-6-19 Venereal disease -- Examination and treatment of persons in prison or jail.

(1) All persons confined in any state, county, or city prison or jail shall be examined, and if infected, treated for venereal diseases by the health authorities. The prison authorities of every state, county, or city prison or jail shall make available to the health authorities such portion of the prison or jail as may be necessary for a clinic or hospital wherein all persons suffering with venereal disease at the time of the expiration of their terms of imprisonment, shall be isolated and treated at public expense until cured.
(2) The department may require persons suffering with venereal disease at the time of the expiration of their terms of imprisonment to report for treatment to a licensed physician or physician assistant or submit to treatment provided at public expense in lieu of isolation. Nothing in this section shall interfere with the service of any sentence imposed by a court as a punishment for the commission of crime.

Amended by Chapter 349, 2019 General Session

26-6-20 Serological testing of pregnant or recently delivered women.
(1) Every licensed physician and surgeon attending a pregnant or recently delivered woman for conditions relating to her pregnancy shall take or cause to be taken a sample of blood of the woman at the time of first examination or within 10 days thereafter. The blood sample shall be submitted to an approved laboratory for a standard serological test for syphilis. The provisions of this section do not apply to any female who objects thereto on the grounds that she is a bona fide member of a specified, well recognized religious organization whose teachings are contrary to the tests.
(2) Every other person attending a pregnant or recently delivered woman, who is not permitted by law to take blood samples, shall within 10 days from the time of first attendance cause a sample of blood to be taken by a licensed physician or physician assistant. The blood sample shall be submitted to an approved laboratory for a standard serological test for syphilis.
(3) An approved laboratory is a laboratory approved by the department according to its rules governing the approval of laboratories for the purpose of this title. In submitting the sample to the laboratory the physician or physician assistant shall designate whether it is a prenatal test or a test following recent delivery.
(4) For the purpose of this chapter, a "standard serological test" means a test for syphilis approved by the department and made at an approved laboratory.
(5) The laboratory shall transmit a detailed report of the standard serological test, showing the result thereof to the physician or physician assistant.

Amended by Chapter 349, 2019 General Session

26-6-27 Information regarding communicable or reportable diseases confidentiality -- Exceptions.
(1) Information collected pursuant to this chapter in the possession of the department or local health departments relating to an individual who has or is suspected of having a disease designated by the department as a communicable or reportable disease under this chapter shall be held by the department and local health departments as strictly confidential. The department and local health departments may not release or make public that information upon subpoena, search warrant, discovery proceedings, or otherwise, except as provided by this section.
(2) The information described in Subsection (1) may be released by the department or local health departments only in accordance with the requirements of this chapter and as follows:

(a) specific medical or epidemiological information may be released with the written consent of the individual identified in that information or, if that individual is deceased, his next-of-kin;
(b) specific medical or epidemiological information may be released to medical personnel or peace officers in a medical emergency, as determined by the department in accordance with guidelines it has established, only to the extent necessary to protect the health or life of the individual identified in the information, or of the attending medical personnel or law enforcement or public safety officers;
(c) specific medical or epidemiological information may be released 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 when necessary to continue patient services or to undertake public health efforts to interrupt the transmission of disease;
(d) if the individual identified in the information is under the age of 18, the information may be released to the Division of Child and Family Services within the Department of Human Services in accordance with Section 62A-4a-403. If that information is required in a court proceeding involving child abuse or sexual abuse under Title 76, Chapter 5, Offenses Against the Person, the information shall be disclosed in camera and sealed by the court upon conclusion of the proceedings;
(e) specific medical or epidemiological information may be released to authorized personnel in the department or in local health departments, and to the courts, to carry out the provisions of this title, and rules adopted by the department in accordance with this title;
(f) specific medical or epidemiological information may be released to blood banks, organ and tissue banks, and similar institutions for the purpose of identifying individuals with communicable diseases. The department may, by rule, designate the diseases about which information may be disclosed under this subsection, and may choose to release the name of an infected individual to those organizations without disclosing the specific disease;
(g) specific medical or epidemiological information may be released in such a way that no individual is identifiable;
(h) specific medical or epidemiological information may be released to a "health care provider" as defined in Section 78B-3-403, health care personnel, and public health personnel who have 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;
(i) specific medical or epidemiological information regarding a health care provider, as defined in Section 78B-3-403, may be released to the department, the appropriate local health department, and the Division of Occupational and Professional Licensing within the Department of Commerce, if the identified health care provider is endangering the safety or life of any individual by his continued practice of health care; and
(j) specific medical or epidemiological information may be released in accordance with Section 26-6-31 if an individual is not identifiable.
(3) The provisions of Subsection (2)(h) do not create a duty to warn third parties, but is intended only to aid health care providers in their treatment and containment of infectious disease.

Amended by Chapter 150, 2012 General Session
Amended by Chapter 391, 2012 General Session

26-6-28 Protection from examination in legal proceedings -- Exceptions.
(1) Except as provided in Subsection (2), an officer or employee of the department or of a local health department may not be examined in a legal proceeding of any kind or character as to the

existence or content of information retained pursuant to this chapter or obtained as a result of an investigation conducted pursuant to this chapter, without the written consent of the individual who is identified in the information or, if that individual is deceased, the consent of his next-of-kin.

(2) This section does not restrict testimony and evidence provided by an employee or officer of the department or a local health department about:

(a) persons who are under restrictive actions taken by the department in accordance with Subsection 26-6-27(2)(e); or

(b) individuals or groups of individuals subject to examination, treatment, isolation, and quarantine actions under Chapter 6b, Communicable Diseases - Treatment, Isolation, and Quarantine Procedures.

Amended by Chapter 38, 2007 General Session

26-6-29 Violation -- Penalty.

(1) Any individual or entity entitled to receive confidential information from the Department of Health or a local health department under this chapter, other than the individual identified in that information, who violates this chapter by releasing or making public confidential information, or by otherwise breaching the confidentiality requirements of this chapter, is guilty of a class B misdemeanor.

(2) This chapter does not apply to any individual or entity that holds or receives information relating to an individual who has or is suspected of having a disease designated by the department as a communicable or reportable disease under this chapter, if that individual or entity has obtained the information from a source other than the department or a local health department.

Renumbered and Amended by Chapter 201, 1996 General Session

26-6-30 Exclusions from confidentiality requirements.

(1) The provisions of this chapter do not apply to:

(a) information that relates to an individual who is in the custody of the Department of Corrections, a county jail, or the Division of Juvenile Justice Services within the Department of Human Services;

(b) information that relates to an individual who has been in the custody of the Department of Corrections, a county jail, or the Division of Juvenile Justice Services within the Department of Human Services, if liability of either of those departments, a county, or a division, or of an employee of a department, division, or county, is alleged by that individual in a lawsuit concerning transmission of an infectious or communicable disease; or

(c) any information relating to an individual who willfully or maliciously or with reckless disregard for the welfare of others transmits a communicable or infectious disease.

(2) Nothing in this chapter limits the right of the individual identified in the information described in Subsection 26-6-27(1) to disclose that information.

Amended by Chapter 171, 2003 General Session

26-6-31 Public reporting of health care associated infections.

(1) An ambulatory surgical facility, a general acute hospital, a specialty hospital, an end stage renal disease facility, and other facilities as required by rules of the Center for Medicare and Medicaid Services shall give the department access to the facility's data on the incidence and rate of

health care associated infections that the facility submits to the National Healthcare Safety Network in the Center for Disease Control pursuant to the Center for Medicare and Medicaid Services rules for infection reporting. Access to data under this Subsection (1) may include data sharing through the National Healthcare Safety Network.

(2)

(a) The department shall, beginning May 1, 2013, use the data submitted by the facilities in accordance with Subsection (1) to compile an annual report on health care associated infections in ambulatory surgical facilities, general acute hospitals, and specialty hospitals for public distribution in accordance with the requirements of this subsection. The department shall publish the report on the department's website and the Utah Health Exchange.

(b) The department's report under this section shall:

(i) include the following health care associated infections as required by the Center for Medicare and Medicaid Services and protocols adopted by the National Healthcare Safety Network in the Center for Disease Control:

(A) central line associated bloodstream infections;

(B) catheter associated urinary tract infections;

(C) surgical site infections from procedures on the colon or an abdominal hysterectomy;

(D) methicillin-resistant staphylococcus aureus bacteremia;

(E) clostridium difficile of the colon; and

(F) other health care associated infections when reporting is required by the Center for Medicare and Medicaid Services and protocols adopted by the National Healthcare Safety Network in the Center for Disease Control;

(ii) include data on the rate of health care associated infections:

(A) for the infection types described in Subsection (2)(b)(i); and

(B) by health care facility or hospital;

(iii) include data on how the rate of health care associated infections in ambulatory surgical facilities, general acute hospitals, and specialty hospitals compares with the rates in other states;

(iv) in compiling the report described in Subsection (2)(a), use analytical methodologies that meet accepted standards of validity and reliability;

(v) clearly identify and acknowledge, in the report, the limitations of the data sources and analytic methodologies used to develop comparative facility or hospital information;

(vi) decide whether information supplied by a facility or hospital under Subsection (1) is appropriate to include in the report;

(vii) adjust comparisons among facilities and hospitals for patient case mix and other relevant factors, when appropriate; and

(viii) control for provider peer groups, when appropriate.

(3) Before posting or releasing the report described in Subsection (2)(a), the department shall:

(a) disclose to each ambulatory surgical facility, general acute hospital, and specialty hospital whose data is included in the report:

(i) the entire methodology for analyzing the data; and

(ii) the comparative facility or hospital information and other information the department has compiled for the facility or hospital; and

(b) give the facility or hospital 30 days to suggest corrections or add explanatory comments about the data.

(4) The department shall develop and implement effective safeguards to protect against the unauthorized use or disclosure of ambulatory surgical facility, general acute hospital, and

specialty hospital data, including the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective data.

(5) The report described in Subsection (2)(a):

(a) may include data that compare and identify general acute hospitals, ambulatory surgical centers, and specialty hospitals;

(b) shall contain only statistical, non-identifying information and may not disclose the identity of:

(i) an employee of an ambulatory surgical facility, a general acute hospital, or a specialty hospital;

(ii) a patient; or

(iii) a health care provider licensed under Title 58, Occupations and Professions; and

(c) may not be used as evidence in a criminal, civil, or administrative proceeding.

(6) This section does not limit the department's authority to investigate and collect data regarding infections and communicable diseases under other provisions of state or federal law.

Enacted by Chapter 150, 2012 General Session

Chapter 6b
Communicable Diseases - Treatment, Isolation, and Quarantine Procedures

26-6b-1 Applicability of chapter -- Administrative procedures.

(1) This chapter applies to involuntary examination, treatment, isolation, and quarantine actions applied to individuals or groups of individuals by the department or a local health department.

(2) The provisions of this chapter supersede the provisions of Title 63G, Chapter 4, Administrative Procedures Act.

(3) The Department of Health may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to administer the provisions of this chapter.

Amended by Chapter 382, 2008 General Session

26-6b-2 Definitions.

As used in this chapter:

(1) "Department" means the Department of Health or a local health department as defined in Section 26A-1-102.

(2) "First responder" means:

(a) a law enforcement officer as defined in Section 53-13-103;

(b) emergency medical service personnel as defined in Section 26-8a-102;

(c) firefighters; and

(d) public health personnel having jurisdiction over the location where an individual subject to restriction is found.

(3) "Order of restriction" means an order issued by a department or a district court which requires an individual or group of individuals who are subject to restriction to submit to an examination, treatment, isolation, or quarantine.

(4) "Public health official" means:

(a) the executive director of the Department of Health, or the executive director's authorized representative; or

(b) the executive director of a local health department as defined in Section 26A-1-102, or the executive director's authorized representative.

(5) "Subject to restriction" as applied to an individual, or a group of individuals, means the individual or group of individuals is:

(a) infected or suspected to be infected with a communicable disease that poses a threat to the public health and who does not take action as required by the department to prevent spread of the disease;

(b) contaminated or suspected to be contaminated with an infectious agent that poses a threat to the public health, and that could be spread to others if remedial action is not taken;

(c) in a condition or suspected condition which, if the individual is exposed to others, poses a threat to public health, or is in a condition which if treatment is not completed the individual will pose a threat to public health; or

(d) contaminated or suspected to be contaminated with a chemical or biological agent that poses a threat to the public health and that could be spread to others if remedial action is not taken.

Amended by Chapter 185, 2006 General Session

26-6b-3 Order of restriction.

(1) The department having jurisdiction over the location where an individual or a group of individuals who are subject to restriction are found may:

(a) issue a written order of restriction for the individual or group of individuals pursuant to Section 26-1-30 or Subsection 26A-1-114(1)(b) upon compliance with the requirements of this chapter; and

(b) issue a verbal order of restriction for an individual or group of individuals pursuant to Subsection (2)(c).

(2)

(a) A department's determination to issue an order of restriction shall be based upon the totality of circumstances reported to and known by the department, including:

(i) observation;

(ii) information that the department determines is credible and reliable information; and

(iii) knowledge of current public health risks based on medically accepted guidelines as may be established by the Department of Health by administrative rule.

(b) An order of restriction issued by a department shall:

(i) in the opinion of the public health official, be for the shortest reasonable period of time necessary to protect the public health;

(ii) use the least intrusive method of restriction that, in the opinion of the department, is reasonable based on the totality of circumstances known to the health department issuing the order of restriction;

(iii) be in writing unless the provisions of Subsection (2)(c) apply; and

(iv) contain notice of an individual's rights as required in Section 26-6b-3.3.

(c)

(i) A department may issue a verbal order of restriction, without prior notice to the individual or group of individuals if the delay in imposing a written order of restriction would significantly jeopardize the department's ability to prevent or limit:

(A) the transmission of a communicable or possibly communicable disease that poses a threat to public health;

(B) the transmission of an infectious agent or possibly infectious agent that poses a threat to public health;

(C) the exposure or possible exposure of a chemical or biological agent that poses a threat to public health; or
(D) the exposure or transmission of a condition that poses a threat to public health.
(ii) A verbal order of restriction issued under the provisions of Subsection (2)(c)(i):
(A) is valid for 24 hours from the time the order of restriction is issued;
(B) may be verbally communicated to the individuals or group of individuals subject to restriction by a first responder;
(C) may be enforced by the first responder until the department is able to establish and maintain the place of restriction; and
(D) may only be continued beyond the initial 24 hours if a written order of restriction is issued pursuant to the provisions of Section 26-6b-3.3.
(3) Pending issuance of a written order of restriction under Section 26-6b-3.3, or judicial review of an order of restriction by the district court pursuant to Section 26-6b-6, an individual who is subject to the order of restriction may be required to submit to involuntary examination, quarantine, isolation, or treatment in the individual's home, a hospital, or any other suitable facility under reasonable conditions prescribed by the department.
(4) The department that issued the order of restriction shall take reasonable measures, including the provision of medical care, as may be necessary to assure proper care related to the reason for the involuntary examination, treatment, isolation, or quarantine of an individual ordered to submit to an order of restriction.

Amended by Chapter 73, 2015 General Session

26-6b-3.1 Consent to order of restriction -- Periodic review.
(1)
(a) The department shall either seek judicial review of an order of restriction under Sections 26-6b-4 through 26-6b-6, or obtain the consent of an individual subject to an order of restriction.
(b) If the department obtains consent, the consent shall be in writing and shall inform the individual or group of individuals:
(i) of the terms and duration of the order of restriction;
(ii) of the importance of complying with the order of restriction to protect the public's health;
(iii) that each individual has the right to agree to the order of restriction, or refuse to agree to the order of restriction and seek a judicial review of the order of restriction;
(iv) that for any individual who consents to the order of restriction:
(A) the order of restriction will not be reviewed by the district court unless the individual withdraws consent to the order of restriction in accordance with Subsection (1)(b)(iv)(B); and
(B) the individual shall notify the department in writing, with at least five business day's notice, if the individual intends to withdraw consent to the order of restriction; and
(v) that a breach of a consent agreement prior to the end of the order of restriction may subject the individual to an involuntary order of restriction under Section 26-6b-3.2.
(2)
(a) The department responsible for the care of an individual who has consented to the order of restriction shall periodically reexamine the reasons upon which the order of restriction was based. This reexamination shall occur at least once every six months.
(b)

(i) If at any time, the department determines that the conditions justifying the order of restriction for either a group or an individual no longer exist, the department shall immediately discharge the individual or group from the order of restriction.
(ii) If the department determines that the conditions justifying the order of restriction continue to exist, the department shall send to the individual a written notice of:
(A) the department's findings, the expected duration of the order of restriction, and the reason for the decision; and
(B) the individual's right to a judicial review of the order of restriction by the district court if requested by the individual.
(iii) Upon request for judicial review by an individual, the department shall:
(A) file a petition in district court within five business days after the individual's request for a judicial review; and
(B) proceed under Sections 26-6b-4 through 26-6b-6.

Amended by Chapter 297, 2011 General Session

26-6b-3.2 Involuntary order of restriction -- Notice -- Effect of order during judicial review.
(1) If the department cannot obtain consent to the order of restriction from an individual, or if an individual withdraws consent to an order under Subsection 26-6b-3.1(1)(b)(iv)(B), the department shall:
(a) give the individual or group of individuals subject to the order of restriction a written notice of:
(i) the order of restriction and any supporting documentation; and
(ii) the individual's right to a judicial review of the order of restriction; and
(b) file a petition for a judicial review of the order of restriction under Section 26-6b-4 in district court within:
(i) five business days after issuing the written notice of the order of restriction; or
(ii) if consent has been withdrawn under Subsection 26-6b-3.1(1)(b)(iv)(B), within five business days after receiving notice of the individual's withdrawal of consent.
(2)
(a) An order of restriction remains in effect during any judicial proceedings to review the order of restriction if the department files a petition for judicial review of the order of restriction with the district within the period of time required by this section.
(b) Law enforcement officers with jurisdiction in the area where the individual who is subject to the order of restriction can be located shall assist the department with enforcing the order of restriction.

Enacted by Chapter 185, 2006 General Session

26-6b-3.3 Contents of notice of order of restriction -- Rights of individuals.
(1) A written order of restriction issued by a department shall include the following information:
(a) the identity of the individual or a description of the group of individuals subject to the order of restriction;
(b) the identity or location of any premises that may be subject to restriction;
(c) the date and time for which the restriction begins and the expected duration of the restriction;
(d) the suspected communicable disease, infectious, chemical or biological agent, or other condition that poses a threat to public health;

(e) the requirements for termination of the order of restriction, such as necessary laboratory reports, the expiration of an incubation period, or the completion of treatment for the communicable disease;
(f) any conditions on the restriction, such as limitation of visitors or requirements for medical monitoring;
(g) the medical or scientific information upon which the restriction is based;
(h) a statement advising of the right to a judicial review of the order of restriction by the district court; and
(i) pursuant to Subsection (2), the rights of each individual subject to restriction.

(2) An individual subject to restriction has the following rights:
(a) the right to be represented by legal counsel in any judicial review of the order of restriction in accordance with Subsection 26-6b-4(3);
(b) the right to be provided with prior notice of the date, time, and location of any hearing concerning the order of restriction;
(c) the right to participate in any hearing, in a manner established by the court based on precautions necessary to prevent additional exposure to communicable or possibly communicable diseases or to protect the public health;
(d) the right to respond and present evidence and arguments on the individual's own behalf in any hearing;
(e) the right to cross examine witnesses; and
(f) the right to review and copy all records in the possession of the department that issued the order of restriction which relate to the subject of the written order of restriction.

(3)
(a) Notwithstanding the provisions of Subsection (1), if a department issues an order of restriction for a group of individuals, the department may modify the method of providing notice to the group or modify the information contained in the notice, if the public health official determines the modification of the notice is necessary to:
(i) protect the privacy of medical information of individuals in the group; or
(ii) provide notice to the group in a manner that will efficiently and effectively notify the individuals in the group within the period of time necessary to protect the public health.
(b) When a department modifies notice to a group of individuals under Subsection (3)(a), the department shall provide each individual in the group with notice that complies with the provisions of Subsection (1) as soon as reasonably practical.

(4)
(a) In addition to the rights of an individual described in Subsections (1) and (2), an individual subject to an order of restriction may not be terminated from employment if the reason for termination is based solely on the fact that the individual is or was subject to an order of restriction.
(b) The department issuing the order of restriction shall give the individual subject to the order of restriction notice of the individual's employment rights under Subsection (4)(a).
(c) An employer in the state, including an employer who is the state or a political subdivision of the state, may not violate the provisions of Subsection (4)(a).

Amended by Chapter 115, 2008 General Session

26-6b-3.4 Medical records -- Privacy protections.

(1)

(a) Health care providers as defined in Section 78B-3-403, health care facilities licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, and governmental entities, shall, when requested, provide the public health official and the individual subject to an order of restriction, a copy of medical records that are relevant to the order of restriction.
(b) The records requested under Subsection (1)(a) shall be provided as soon as reasonably possible after the request is submitted to the health care provider or health care facility, or as soon as reasonably possible after the health care provider or facility receives the results of any relevant diagnostic testing of the individual.

(2)
(a) The production of records under the provisions of this section is for the benefit of the public health and safety of the citizens of the state. A health care provider or facility is encouraged to provide copies of medical records or other records necessary to carry out the purpose of this chapter free of charge.
(b) Notwithstanding the provisions of Subsection (2)(c), a health care facility that is a state governmental entity shall provide medical records or other records necessary to carry out the purposes of this chapter, free of charge.
(c) If a health care provider or health care facility does not provide medical records free of charge under the provisions of Subsection (2)(a) or (b), the health care provider or facility may charge a fee for the records that does not exceed the presumed reasonable charges established for workers' compensation by administrative rule adopted by the Labor Commission.

(3) Medical records held by a court related to orders of restriction under this chapter shall be sealed by the district court at the conclusion of the case.

Amended by Chapter 3, 2008 General Session
Amended by Chapter 115, 2008 General Session

26-6b-4 Judicial review by the district court -- Required notice -- Representation by counsel -- Conduct of proceedings.

(1) The provisions of this section and Sections 26-6b-5 through 26-6b-7 apply if a department issues an order for restriction, and:
(a) an individual subject to the order of restriction refuses to consent to the order of restriction;
(b) an individual subject to an order of restriction has withdrawn consent to an order of restriction under the provisions of Subsection 26-6b-3.1(1)(b)(iv)(B); or
(c) the department chooses to not attempt to obtain consent to an order of restriction and files an action for judicial review of the order of restriction.

(2)
(a) If the individual who is subject to an order of restriction is in custody, the department, which is the petitioner, shall provide to the individual written notice of the petition for judicial review of the order of restriction and hearings held pursuant to Sections 26-6b-5 through 26-6b-7 as soon as practicable, and shall send the notice to the legal guardian, legal counsel for the parties involved, and any other persons and immediate adult family members whom the individual or the district court designates. The notice shall advise these persons that a hearing may be held within the time provided by this chapter.
(b) If the individual has refused to permit release of information necessary for the provision of notice under this Subsection (2), the extent of notice shall be determined by the district court.
(c) Notwithstanding the notice requirement in Subsection (2)(a), if the court determines that written notice to each individual in a group of individuals subject to an order of restriction is not practical considering the circumstances of the threat to public health, the court may

order the department to provide notice to the individual or group of individuals in a manner determined by the court.

(3)

(a) If the individual who is subject to an order of restriction is in custody, he shall be afforded an opportunity to be represented by counsel. If neither the individual nor others provide for counsel, the district court shall appoint counsel and allow counsel sufficient time to consult with the individual prior to the hearing. If the individual is indigent, the payment of reasonable attorney fees for counsel, as determined by the district court, shall be made by the county in which the individual resides or was found.

(b) The parties may appear at the hearings, to testify, and to present and cross-examine witnesses. The district court may, in its discretion, receive the testimony of any other individual.

(c) The district court may allow a waiver of the individual's right to appear only for good cause shown, and that cause shall be made a part of the court record.

(d) The district court may order that the individual participate in the hearing by telephonic or other electronic means if the individual's condition poses a health threat to those who physically attend the hearing or to others if the individual is transported to the court.

(4) The district court may, in its discretion, order that the individual be moved to a more appropriate treatment, quarantine, or isolation facility outside of its jurisdiction, and may transfer the proceedings to any other district court within this state where venue is proper, provided that the transfer will not be adverse to the legal interests of the individual.

(5) All persons to whom notice is required to be given may attend the hearings. The district court may exclude from the hearing all persons not necessary for the conduct of the proceedings.

(6) All hearings shall be conducted in as informal a manner as may be consistent with orderly procedure, and in a physical setting that is not likely to have a harmful effect on the health of the individual or others required to participate in the hearing.

(7) The district court shall receive all relevant and material evidence which is offered, subject to Utah Rules of Evidence.

(8) The district court may order law enforcement to assist the petitioner in locating the individuals subject to restriction and enforcing the order of restriction.

Amended by Chapter 115, 2008 General Session

26-6b-5 Petition for judicial review of order of restriction -- Court-ordered examination period.

(1)

(a) A department may petition for a judicial review of the department's order of restriction for an individual or group of individuals who are subject to restriction by filing a written petition with the district court of the county in which the individual or group of individuals reside or are located.

(b)

(i) The county attorney for the county where the individual or group of individuals reside or are located shall represent the local health department in any proceedings under this chapter.

(ii) The Office of the Attorney General shall represent the department when the petitioner is the Department of Health in any proceedings under this chapter.

(2) The petition under Subsection (1) shall be accompanied by:

(a) written affidavit of the department stating:

(i) a belief the individual or group of individuals are subject to restriction;

(ii) a belief that the individual or group of individuals who are subject to restriction are likely to fail to submit to examination, treatment, quarantine, or isolation if not immediately restrained;
(iii) this failure would pose a threat to the public health; and
(iv) the personal knowledge of the individual's or group of individuals' condition or the circumstances that lead to that belief; and
(b) a written statement by a licensed physician or physician assistant indicating the physician or physician assistant finds the individual or group of individuals are subject to restriction.
(3) The court shall issue an order of restriction requiring the individual or group of individuals to submit to involuntary restriction to protect the public health if the district court finds:
(a) there is a reasonable basis to believe that the individual's or group of individuals' condition requires involuntary examination, quarantine, treatment, or isolation pending examination and hearing; or
(b) the individual or group of individuals have refused to submit to examination by a health professional as directed by the department or to voluntarily submit to examination, treatment, quarantine, or isolation.
(4) If the individual or group of individuals who are subject to restriction are not in custody, the court may make its determination and issue its order of restriction in an ex parte hearing.
(5) At least 24 hours prior to the hearing required by Section 26-6b-6, the department which is the petitioner, shall report to the court, in writing, the opinion of qualified health care providers:
(a) regarding whether the individual or group of individuals are infected by or contaminated with:
(i) a communicable or possible communicable disease that poses a threat to public health;
(ii) an infectious agent or possibly infectious agent that poses a threat to public health;
(iii) a chemical or biological agent that poses a threat to public health; or
(iv) a condition that poses a threat to public health;
(b) that despite the exercise of reasonable diligence, the diagnostic studies have not been completed;
(c) whether the individual or group of individuals have agreed to voluntarily comply with necessary examination, treatment, quarantine, or isolation; and
(d) whether the petitioner believes the individual or group of individuals will comply without court proceedings.

Amended by Chapter 349, 2019 General Session

26-6b-6 Court determination for an order of restriction after examination period.
(1) The district court shall set a hearing regarding the involuntary order of restriction of an individual or group of individuals, to be held within 10 business days of the issuance of its order of restriction issued pursuant to Section 26-6b-5, unless the petitioner informs the district court prior to this hearing that the individual or group of individuals:
(a) are not subject to restriction; or
(b) have stipulated to the issuance of an order of restriction.
(2) If the individual or an individual in a group of individuals has stipulated to the issuance of an order of restriction, the court may issue an order as provided in Subsection (6) for those individuals without further hearing.
(3)
(a) If the examination report required in Section 26-6b-5 proves the individual or group of individuals are not subject to restriction, the court may without further hearing terminate the proceedings and dismiss the petition.

(b) The court may, after a hearing at which the individual or group of individuals are present in person or by telephonic or other electronic means and have had the opportunity to be represented by counsel, extend its order of restriction for a reasonable period, not to exceed 90 days, if the court has reason to believe the individual or group of individuals are infected by or contaminated with:

(i) a communicable or possibly communicable disease that poses a threat to public health;

(ii) an infectious agent or possibly infectious agent that poses a threat to public health;

(iii) a chemical or biological agent that poses a threat to public health; or

(iv) a condition that poses a threat to public health, but, despite the exercise of reasonable diligence the diagnostic studies have not been completed.

(4) The petitioner shall, at the time of the hearing, provide the district court with the following items, to the extent that they have been issued or are otherwise available:

(a) the order of restriction issued by the petitioner;

(b) admission notes if any individual was hospitalized; and

(c) medical records pertaining to the current order of restriction.

(5) The information provided to the court under Subsection (4) shall also be provided to the individual's or group of individual's counsel at the time of the hearing, and at any time prior to the hearing upon request of counsel.

(6)

(a) The district court shall order the individual and each individual in a group of individuals to submit to the order of restriction if, upon completion of the hearing and consideration of the record, it finds by clear and convincing evidence that:

(i) the individual or group of individuals are infected with a communicable disease or infectious agent, are contaminated with a chemical or biological agent, or are in a condition that poses a threat to public health;

(ii) there is no appropriate and less restrictive alternative to a court order of examination, quarantine, isolation, and treatment, or any of them;

(iii) the petitioner can provide the individual or group of individuals with treatment that is adequate and appropriate to the individual's or group of individuals' conditions and needs; and

(iv) it is in the public interest to order the individual or group of individuals to submit to involuntary examination, quarantine, isolation, and treatment, or any of them after weighing the following factors:

(A) the personal or religious beliefs, if any, of the individual that are opposed to medical examination or treatment;

(B) the ability of the department to control the public health threat with treatment alternatives that are requested by the individual;

(C) the economic impact for the department if the individual is permitted to use an alternative to the treatment recommended by the department; and

(D) other relevant factors as determined by the court.

(b) If upon completion of the hearing the court does not find all of the conditions listed in Subsection (6)(a) exist, the court shall immediately dismiss the petition.

(7) The order of restriction shall designate the period, subject to Subsection (8), for which the individual or group of individuals shall be examined, treated, isolated, or quarantined.

(8)

(a) The order of restriction may not exceed six months without benefit of a district court review hearing.

(b) The district court review hearing shall be held prior to the expiration of the order of restriction issued under Subsection (7). At the review hearing the court may issue an order of restriction for up to an indeterminate period, if the district court enters a written finding in the record determining by clear and convincing evidence that the required conditions in Subsection (6) will continue for an indeterminate period.

Amended by Chapter 115, 2008 General Session

26-6b-7 Periodic review of individuals under court order.

(1) At least two weeks prior to the expiration of the designated period of any court order still in effect, the petitioner shall inform the court that issued the order that the order is about to expire. The petitioner shall immediately reexamine the reasons upon which the court's order was based. If the petitioner determines that the conditions justifying that order no longer exist, it shall discharge the individual from involuntary quarantine, isolation, or treatment and report its action to the court for a termination of the order. Otherwise, the court shall schedule a hearing prior to the expiration of its order and proceed under Sections 26-6b-4 through 26-6b-6.

(2) The petitioner responsible for the care of an individual under a court order of involuntary quarantine, isolation, or treatment for an indeterminate period shall at six-month intervals reexamine the reasons upon which the order of indeterminate duration was based. If the petitioner determines that the conditions justifying that the court's order no longer exist, the petitioner shall discharge the individual from involuntary quarantine, isolation, or treatment and immediately report its action to the court for a termination of the order. If the petitioner determines that the conditions justifying the involuntary quarantine, isolation, or treatment continue to exist, the petitioner shall send a written report of those findings to the court. The petitioner shall notify the individual and his counsel of record in writing that the involuntary quarantine, isolation, or treatment will be continued, the reasons for that decision, and that the individual has the right to a review hearing by making a request to the court. Upon receiving the request for a review, the court shall immediately set a hearing date and proceed under Sections 26-6b-4 through 26-6b-6.

Enacted by Chapter 211, 1996 General Session

26-6b-8 Transportation of individuals subject to temporary or court-ordered restriction.

Transportation of an individual subject to an order of restriction to court, or to a place for examination, quarantine, isolation, or treatment pursuant a temporary order issued by a department, or pursuant to a court order, shall be conducted by the county sheriff where the individual is located.

Amended by Chapter 185, 2006 General Session

26-6b-9 Examination, quarantine, isolation, and treatment costs.

If a local health department obtains approval from the Department of Health, the costs that the local health department would otherwise have to bear for examination, quarantine, isolation, and treatment ordered under the provisions of this chapter shall be paid by the Department of Health to the extent that the individual is unable to pay and that other sources and insurance do not pay.

Amended by Chapter 185, 2006 General Session

26-6b-10 Severability.

If any provision of this chapter, or the application of this chapter to any person or circumstance, is found to be unconstitutional, the provision is severable and the balance of this chapter remains effective, notwithstanding that unconstitutionality.

Enacted by Chapter 211, 1996 General Session

Chapter 7
Health Promotion and Risk Reduction

26-7-1 Identification of major risk factors by department -- Education of public -- Establishment of programs.

The department shall identify the major risk factors contributing to injury, sickness, death, and disability within the state and where it determines that a need exists, educate the public regarding these risk factors, and the department may establish programs to reduce or eliminate these factors except that such programs may not be established if adequate programs exist in the private sector.

Amended by Chapter 297, 2011 General Session

26-7-2 Office of Health Disparities Reduction -- Duties.

(1) As used in this section:
  (a) "Multicultural or minority health issue" means a health issue, including a mental and oral health issue, of particular interest to cultural, ethnic, racial, or other subpopulations, including:
    (i) disparities in:
      (A) disease incidence, prevalence, morbidity, mortality, treatment, and treatment response; and
      (B) access to care; and
    (ii) cultural competency in the delivery of health care.
  (b) "Office" means the Office of Health Disparities Reduction created in this section.
(2) There is created within the department the Office of Health Disparities Reduction.
(3) The office shall:
  (a) promote and coordinate the research, data production, dissemination, education, and health promotion activities of the following that relate to a multicultural or minority health issue:
    (i) the department;
    (ii) local health departments;
    (iii) local mental health authorities;
    (iv) public schools;
    (v) community-based organizations; and
    (vi) other organizations within the state;
  (b) assist in the development and implementation of one or more programs to address a multicultural or minority health issue;
  (c) promote the dissemination and use of information on a multicultural or minority health issue by minority populations, health care providers, and others;
  (d) seek federal funding and other resources to accomplish the office's mission;
  (e) provide technical assistance to organizations within the state seeking funding to study or address a multicultural or minority health issue;

(f) develop and increase the capacity of the office to:
(i) ensure the delivery of qualified timely culturally appropriate translation services across department programs; and
(ii) provide, when appropriate, linguistically competent translation and communication services for limited English proficiency individuals;
(g) provide staff assistance to any advisory committee created by the department to study a multicultural or minority health issue; and
(h) annually report to the Legislature on its activities and accomplishments.

Amended by Chapter 192, 2011 General Session

26-7-2.5 American Indian-Alaskan Native Health Liaison -- Duties.
(1) As used in this section:
(a) "Health care" means care, treatment, service, or a procedure to improve, maintain, diagnose, or otherwise affect an individual's physical or mental condition.
(b) "Liaison" means the American Indian-Alaskan Native Health Liaison appointed under this section.
(2) Subject to budget constraints, the executive director shall appoint an individual as the American Indian-Alaskan Native Health Liaison.
(3) The liaison shall on behalf of the executive director and the department:
(a) promote and coordinate collaborative efforts between the department and Utah's American Indian population to improve the availability and accessibility of quality health care impacting Utah's American Indian populations on and off reservations;
(b) interact with the following to improve health disparities for Utah's American Indian populations:
(i) tribal health programs;
(ii) local health departments;
(iii) state agencies and officials; and
(iv) providers of health care in the private sector;
(c) facilitate education, training, and technical assistance regarding public health and medical assistance programs to Utah's American Indian populations; and
(d) staff an advisory board by which Utah's tribes may consult with state and local agencies for the development and improvement of public health programs designed to address improved health care for Utah's American Indian populations on and off the reservation.
(4) The liaison shall annually report the liaison's activities and accomplishments to the Native American Legislative Liaison Committee created in Section 36-22-1.

Enacted by Chapter 192, 2011 General Session

26-7-4 Utah Registry of Autism and Developmental Disabilities.
(1) As used in this section, "URADD" means the Utah Registry of Autism and Developmental Disabilities.
(2) The department may enter into an agreement with:
(a) the University of Utah or another person for the operation of URADD; and
(b) a person to conduct a public education campaign to:
(i) improve public awareness of the early warning signs of autism spectrum disorders and developmental disabilities; and
(ii) promote the early identification of autism spectrum disorders and developmental disabilities.

(3) URADD shall consist of a database that collects information on people in the state who have an autism spectrum disorder or a developmental disability.
(4) The purpose of URADD is to assist health care providers to:
(a) determine the risk factors and causes of autism spectrum disorders and developmental disabilities;
(b) plan for and develop resources, therapies, methods of diagnoses, and other services for people with an autism spectrum disorder or a developmental disability;
(c) facilitate measuring and tracking of treatment outcomes;
(d) gather statistics relating to autism spectrum disorders and developmental disabilities; and
(e) improve coordination and cooperation between agencies and other programs that provide services to people with an autism spectrum disorder or a developmental disability.

Enacted by Chapter 72, 2008 General Session

26-7-7 Radon awareness campaign.

The department shall, in consultation with the Division of Waste Management and Radiation Control, develop a statewide electronic awareness campaign to educate the public regarding:
(1) the existence and prevalence of radon gas in buildings and structures;
(2) the health risks associated with radon gas;
(3) options for radon gas testing; and
(4) options for radon gas remediation.

Amended by Chapter 451, 2015 General Session

26-7-8 Syringe exchange and education.

(1) The following may operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs, and those individuals' contacts:
(a) a government entity, including:
(i) the department;
(ii) a local health department, as defined in Section 26A-1-102;
(iii) the Division of Substance Abuse and Mental Health within the Department of Human Services; or
(iv) a local substance abuse authority, as defined in Section 62A-15-102;
(b) a nongovernment entity, including:
(i) a nonprofit organization; or
(ii) a for-profit organization; or
(c) any other entity that complies with Subsections (2) and (4).
(2) An entity operating a syringe exchange program in the state shall:
(a) facilitate the exchange of an individual's used syringe for one or more new syringes in sealed sterile packages;
(b) ensure that a recipient of a new syringe is given verbal and written instruction on:
(i) methods for preventing the transmission of blood-borne diseases, including hepatitis C and human immunodeficiency virus; and
(ii) options for obtaining:
(A) services for the treatment of a substance use disorder;
(B) testing for a blood-borne disease; and
(C) an opiate antagonist under Chapter 55, Opiate Overdose Response Act; and

(c) report annually to the department the following information about the program's activities:
(i) the number of individuals who have exchanged syringes;
(ii) the number of used syringes exchanged for new syringes; and
(iii) the number of new syringes provided in exchange for used syringes.
(3) No later than October 1, 2017, and every two years thereafter, the department shall report to the Legislature's Health and Human Services Interim Committee on:
(a) the activities and outcomes of syringe programs operating in the state, including:
(i) the number of individuals who have exchanged syringes;
(ii) the number of used syringes exchanged for new syringes;
(iii) the number of new syringes provided in exchange for used syringes;
(iv) the impact of the programs on blood-borne infection rates; and
(v) the impact of the programs on the number of individuals receiving treatment for a substance use disorder;
(b) the potential for additional reductions in the number of syringes contaminated with blood-borne disease if the programs receive additional funding;
(c) the potential for additional reductions in state and local government spending if the programs receive additional funding;
(d) whether the programs promote illicit use of drugs; and
(e) whether the programs should be continued, continued with modifications, or terminated.
(4) The department shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying how and when an entity operating a syringe exchange program shall make the report required by Subsection (2)(c).

Amended by Chapter 281, 2018 General Session

26-7-9 Online public health education module.
(1) As used in this section:
(a) "Health care provider" means the same as that term is defined in Section 78B-3-403.
(b) "Nonimmune" means that a child or an individual:
(i) has not received each vaccine required in Section 53G-9-305 and has not developed a natural immunity through previous illness to a vaccine-preventable disease, as documented by a health care provider;
(ii) cannot receive each vaccine required in Section 53G-9-305; or
(iii) is otherwise known to not be immune to a vaccine-preventable disease.
(c) "Vaccine-preventable disease" means an infectious disease that can be prevented by a vaccination required in Section 53G-9-305.
(2) The department shall develop an online education module regarding vaccine-preventable diseases:
(a) to assist a parent of a nonimmune child to:
(i) recognize the symptoms of vaccine-preventable diseases;
(ii) respond in the case of an outbreak of a vaccine-preventable disease;
(iii) protect children who contract a vaccine-preventable disease; and
(iv) prevent the spread of vaccine-preventable diseases;
(b) that contains only the following:
(i) information about vaccine-preventable diseases necessary to achieve the goals stated in Subsection (2)(a), including the best practices to prevent the spread of vaccine-preventable diseases;

(ii) recommendations to reduce the likelihood of a nonimmune individual contracting or transmitting a vaccine-preventable disease; and
(iii) information about additional available resources related to vaccine-preventable diseases and the availability of low-cost vaccines;
(c) that includes interactive questions or activities; and
(d) that is expected to take an average user 20 minutes or less to complete, based on user testing.
(3) In developing the online education module described in Subsection (2), the department shall consult with individuals interested in vaccination or vaccine-preventable diseases, including:
(a) representatives from organizations of health care professionals; and
(b) parents of nonimmune children.
(4) The department shall make the online education module described in Subsection (2) publicly available to parents through:
(a) a link on the department's website;
(b) county health departments, as that term is defined in Section 26A-1-102;
(c) local health departments, as that term is defined in Section 26A-1-102;
(d) local education agencies, as that term is defined in Section 53E-1-102; and
(e) other public health programs or organizations.

Amended by Chapter 186, 2019 General Session

Chapter 8a
Utah Emergency Medical Services System Act

Part 1
General Provisions

26-8a-101 Title.
This chapter is known as the "Utah Emergency Medical Services System Act."

Enacted by Chapter 141, 1999 General Session

26-8a-102 Definitions.
As used in this chapter:
(1)
(a) "911 ambulance or paramedic services" means:
(i) either:
(A) 911 ambulance service;
(B) 911 paramedic service; or
(C) both 911 ambulance and paramedic service; and
(ii) a response to a 911 call received by a designated dispatch center that receives 911 or E911 calls.
(b) "911 ambulance or paramedic service" does not mean a seven or ten digit telephone call received directly by an ambulance provider licensed under this chapter.
(2) "Ambulance" means a ground, air, or water vehicle that:
(a) transports patients and is used to provide emergency medical services; and

(b) is required to obtain a permit under Section 26-8a-304 to operate in the state.
(3) "Ambulance provider" means an emergency medical service provider that:
(a) transports and provides emergency medical care to patients; and
(b) is required to obtain a license under Part 4, Ambulance and Paramedic Providers.
(4) "Committee" means the State Emergency Medical Services Committee created by Section 26-1-7.
(5) "Direct medical observation" means in-person observation of a patient by a physician, registered nurse, physician's assistant, or individual licensed under Section 26-8a-302.
(6) "Emergency medical condition" means:
(a) a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
(i) placing the individual's health in serious jeopardy;
(ii) serious impairment to bodily functions; or
(iii) serious dysfunction of any bodily organ or part; or
(b) a medical condition that in the opinion of a physician or his designee requires direct medical observation during transport or may require the intervention of an individual licensed under Section 26-8a-302 during transport.
(7) "Emergency medical service personnel":
(a) means an individual who provides emergency medical services to a patient and is required to be licensed under Section 26-8a-302; and
(b) includes a paramedic, medical director of a licensed emergency medical service provider, emergency medical service instructor, and other categories established by the committee.
(8) "Emergency medical service providers" means:
(a) licensed ambulance providers and paramedic providers;
(b) a facility or provider that is required to be designated under Subsection 26-8a-303(1)(a); and
(c) emergency medical service personnel.
(9) "Emergency medical services" means medical services, transportation services, or both rendered to a patient.
(10) "Emergency medical service vehicle" means a land, air, or water vehicle that is:
(a) maintained and used for the transportation of emergency medical personnel, equipment, and supplies to the scene of a medical emergency; and
(b) required to be permitted under Section 26-8a-304.
(11) "Governing body":
(a) is as defined in Section 11-42-102; and
(b) for purposes of a "special service district" under Section 11-42-102, means a special service district that has been delegated the authority to select a provider under this chapter by the special service district's legislative body or administrative control board.
(12) "Interested party" means:
(a) a licensed or designated emergency medical services provider that provides emergency medical services within or in an area that abuts an exclusive geographic service area that is the subject of an application submitted pursuant to Part 4, Ambulance and Paramedic Providers;
(b) any municipality, county, or fire district that lies within or abuts a geographic service area that is the subject of an application submitted pursuant to Part 4, Ambulance and Paramedic Providers; or
(c) the department when acting in the interest of the public.

(13) "Medical control" means a person who provides medical supervision to an emergency medical service provider.
(14) "Non-911 service" means transport of a patient that is not 911 transport under Subsection (1).
(15) "Nonemergency secured behavioral health transport" means an entity that:
(a) provides nonemergency secure transportation services for an individual who:
(i) is not required to be transported by an ambulance under Section 26-8a-305; and
(ii) requires behavioral health observation during transport between any of the following facilities:
(A) a licensed acute care hospital;
(B) an emergency patient receiving facility;
(C) a licensed mental health facility; and
(D) the office of a licensed health care provider; and
(b) is required to be designated under Section 26-8a-303.
(16) "Paramedic provider" means an entity that:
(a) employs emergency medical service personnel; and
(b) is required to obtain a license under Part 4, Ambulance and Paramedic Providers.
(17) "Patient" means an individual who, as the result of illness or injury, meets any of the criteria in Section 26-8a-305.
(18) "Political subdivision" means:
(a) a city or town located in a county of the first or second class as defined in Section 17-50-501;
(b) a county of the first or second class;
(c) the following districts located in a county of the first or second class:
(i) a special service district created under Title 17D, Chapter 1, Special Service District Act; or
(ii) a local district under Title 17B, Limited Purpose Local Government Entities - Local Districts, for the purpose of providing fire protection, paramedic, and emergency services;
(d) areas coming together as described in Subsection 26-8a-405.2(2)(b)(ii);
(e) an interlocal entity under Title 11, Chapter 13, Interlocal Cooperation Act; or
(f) a special service district for fire protection service under Subsection 17D-1-201(9).
(19) "Trauma" means an injury requiring immediate medical or surgical intervention.
(20) "Trauma system" means a single, statewide system that:
(a) organizes and coordinates the delivery of trauma care within defined geographic areas from the time of injury through transport and rehabilitative care; and
(b) is inclusive of all prehospital providers, hospitals, and rehabilitative facilities in delivering care for trauma patients, regardless of severity.
(21) "Triage" means the sorting of patients in terms of disposition, destination, or priority. For prehospital trauma victims, triage requires a determination of injury severity to assess the appropriate level of care according to established patient care protocols.
(22) "Triage, treatment, transportation, and transfer guidelines" means written procedures that:
(a) direct the care of patients; and
(b) are adopted by the medical staff of an emergency patient receiving facility, trauma center, or an emergency medical service provider.

Amended by Chapter 265, 2019 General Session

26-8a-103 State Emergency Medical Services Committee -- Membership -- Expenses.
(1) The State Emergency Medical Services Committee created by Section 26-1-7 shall be composed of the following 17 members appointed by the governor, at least six of whom shall reside in a county of the third, fourth, fifth, or sixth class:

(a) five physicians licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, as follows:
(i) one surgeon who actively provides trauma care at a hospital;
(ii) one rural physician involved in emergency medical care;
(iii) two physicians who practice in the emergency department of a general acute hospital; and
(iv) one pediatrician who practices in the emergency department or critical care unit of a general acute hospital or a children's specialty hospital;
(b) two representatives from private ambulance providers;
(c) one representative from an ambulance provider that is neither privately owned nor operated by a fire department;
(d) two chief officers from fire agencies operated by the following classes of licensed or designated emergency medical services providers: municipality, county, and fire district, provided that no class of medical services providers may have more than one representative under this Subsection (1)(d);
(e) one director of a law enforcement agency that provides emergency medical services;
(f) one hospital administrator;
(g) one emergency care nurse;
(h) one paramedic in active field practice;
(i) one emergency medical technician in active field practice;
(j) one licensed emergency medical dispatcher affiliated with an emergency medical dispatch center; and
(k) one consumer.

(2)
(a) Except as provided in Subsection (2)(b), members shall be appointed to a four-year term beginning July 1.
(b) Notwithstanding Subsection (2)(a), the governor:
(i) shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years;
(ii) may not reappoint a member for more than two consecutive terms; and
(iii) shall:
(A) initially appoint the second member under Subsection (1)(b) from a different private provider than the private provider currently serving under Subsection (1)(b); and
(B) thereafter stagger each replacement of a member in Subsection (1)(b) so that the member positions under Subsection (1)(b) are not held by representatives of the same private provider.
(c) When a vacancy occurs in the membership for any reason, the replacement shall be appointed by the governor for the unexpired term.

(3)
(a) Each January, the committee shall organize and select one of its members as chair and one member as vice chair. The committee may organize standing or ad hoc subcommittees, which shall operate in accordance with guidelines established by the committee.
(b) The chair shall convene a minimum of four meetings per year. The chair may call special meetings. The chair shall call a meeting upon request of five or more members of the committee.
(c) Nine members of the committee constitute a quorum for the transaction of business and the action of a majority of the members present is the action of the committee.

(4) 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.
(5) Administrative services for the committee shall be provided by the department.

Amended by Chapter 326, 2017 General Session
Amended by Chapter 336, 2017 General Session

26-8a-104 Committee advisory duties.

The committee shall adopt rules , with the concurrence of the department, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that:
(1) establish licensure and reciprocity requirements under Section 26-8a-302;
(2) establish designation requirements under Section 26-8a-303;
(3) promote the development of a statewide emergency medical services system under Section 26-8a-203;
(4) establish insurance requirements for ambulance providers;
(5) provide guidelines for requiring patient data under Section 26-8a-203;
(6) establish criteria for awarding grants under Section 26-8a-207;
(7) establish requirements for the coordination of emergency medical services and the medical supervision of emergency medical service providers under Section 26-8a-306; and
(8) are necessary to carry out the responsibilities of the committee as specified in other sections of this chapter.

Amended by Chapter 326, 2017 General Session

26-8a-105 Department powers.

The department shall:
(1) coordinate the emergency medical services within the state;
(2) administer this chapter and the rules established pursuant to it;
(3) establish a voluntary task force representing a diversity of emergency medical service providers to advise the department and the committee on rules;
(4) establish an emergency medical service personnel peer review board to advise the department concerning discipline of emergency medical service personnel under this chapter; and
(5) adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:
(a) license ambulance providers and paramedic providers;
(b) permit ambulances, emergency medical response vehicles, and nonemergency secured behavioral health transport vehicles, including approving an emergency vehicle operator's course in accordance with Section 26-8a-304;
(c) establish:
(i) the qualifications for membership of the peer review board created by this section;
(ii) a process for placing restrictions on a license while an investigation is pending;
(iii) the process for the investigation and recommendation by the peer review board; and
(iv) the process for determining the status of a license while a peer review board investigation is pending;
(d) establish application, submission, and procedural requirements for licenses, designations, and permits; and

(e) establish and implement the programs, plans, and responsibilities as specified in other sections of this chapter.

Amended by Chapter 265, 2019 General Session

26-8a-106 Waiver of rules and education and licensing requirements.

(1) Upon application, the department, or the committee with the concurrence of the department, may waive the requirements of a rule the department, or the committee with the concurrence of the department, has adopted if:
  (a) the person applying for the waiver satisfactorily demonstrates that:
    (i) the waiver is necessary for a pilot project to be undertaken by the applicant;
    (ii) in the particular situation, the requirement serves no beneficial public purpose; or
    (iii) circumstances warrant that waiver of the requirement outweighs the public benefit to be gained by adherence to the rule; and
  (b) for a waiver granted under Subsection (1)(a)(ii) or (iii):
    (i) the committee or department extends the waiver to similarly situated persons upon application; or
    (ii) the department, or the committee with the concurrence of the department, amends the rule to be consistent with the waiver.
(2) A waiver of education or licensing requirements may be granted to a veteran, as defined in Section 68-3-12.5, if the veteran:
  (a) provides to the committee or department documentation showing military education and training in the field in which licensure is sought; and
  (b) successfully passes any examination required.
(3) No waiver may be granted under this section that is inconsistent with the provisions of this chapter.

Amended by Chapter 326, 2017 General Session

26-8a-107 Air Ambulance Committee -- Membership -- Duties.

(1) The Air Ambulance Committee created by Section 26-1-7 shall be composed of the following members:
  (a) the state emergency medical services medical director;
  (b) one physician who:
    (i) is licensed under:
      (A)Title 58, Chapter 67, Utah Medical Practice Act;
      (B)Title 58, Chapter 67b, Interstate Medical Licensure Compact; or
      (C)Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
    (ii) actively provides trauma or emergency care at a Utah hospital; and
    (iii) has experience and is actively involved in state and national air medical transport issues;
  (c) one member from each level 1 and level 2 trauma center in the state of Utah, selected by the trauma center the member represents;
  (d) one registered nurse who:
    (i) is licensed under Title 58, Chapter 31b, Nurse Practice Act; and
    (ii) currently works as a flight nurse for an air medical transport provider in the state of Utah;
  (e) one paramedic who:
    (i) is licensed under Title 26, Chapter 8a, Utah Emergency Medical Services System Act; and
    (ii) currently works for an air medical transport provider in the state of Utah; and

(f) two members, each from a different for-profit air medical transport company operating in the state of Utah.

(2) The state emergency medical services medical director shall appoint the physician member under Subsection (1)(b), and the physician shall serve as the chair of the Air Ambulance Committee.

(3) The chair of the Air Ambulance Committee shall:

(a) appoint the Air Ambulance Committee members under Subsections (1)(c) through (f);

(b) designate the member of the Air Ambulance Committee to serve as the vice chair of the committee; and

(c) set the agenda for Air Ambulance Committee meetings.

(4)

(a) Except as provided in Subsection (4)(b), members shall be appointed to a two-year term.

(b) Notwithstanding Subsection (4)(a), the Air Ambulance Committee chair shall, at the time of appointment or reappointment, adjust the length of the terms of committee members to ensure that the terms of the committee members are staggered so that approximately half of the committee is reappointed every two years.

(5)

(a) A majority of the members of the Air Ambulance Committee constitutes a quorum.

(b) The action of a majority of a quorum constitutes the action of the Air Ambulance Committee.

(6) The Air Ambulance Committee shall, before November 30, 2019, and before November 30 of every odd-numbered year thereafter, provide recommendations to the Health and Human Services Interim Committee regarding the development of state standards and requirements related to:

(a) air medical transport provider licensure and accreditation;

(b) air medical transport medical personnel qualifications and training; and

(c) other standards and requirements to ensure patients receive appropriate and high-quality medical attention and care by air medical transport providers operating in the state of Utah.

(7)

(a) The committee shall prepare an annual report, using any data available to the department and in consultation with the Insurance Department, that includes the following information for each air medical transport provider that operates in the state:

(i) which health insurers in the state the air medical transport provider contracts with;

(ii) if sufficient data is available to the committee, the average charge for air medical transport services for a patient who is uninsured or out of network; and

(iii) whether the air medical transport provider balance bills a patient for any charge not paid by the patient's health insurer.

(b) When calculating the average charge under Subsection (7)(a)(ii), the committee shall distinguish between:

(i) a rotary wing provider and a fixed wing provider; and

(ii) any other differences between air medical transport service providers that may substantially affect the cost of the air medical transport service, as determined by the committee.

(c) The department shall:

(i) post the committee's findings under Subsection (7)(a) on the department's website; and

(ii) send the committee's findings under Subsection (7)(a) to each emergency medical service provider, health care facility, and other entity that has regular contact with patients in need of air medical transport provider services.

(8) An Air Ambulance Committee member may not receive compensation, benefits, per diem, or travel expenses for the member's service on the committee.

(9) The Office of the Attorney General shall provide staff support to the Air Ambulance Committee.
(10) The Air Ambulance Committee shall report to the Health and Human Services Interim Committee before November 30, 2023, regarding the sunset of this section in accordance with Section 63I-2-226.

Amended by Chapter 262, 2019 General Session

Part 2
Programs, Plans, and Duties

26-8a-201 Public awareness efforts.

The department may:
(1) develop programs to inform the public of the emergency medical service system; and
(2) develop and disseminate emergency medical training programs for the public, which emphasize the prevention and treatment of injuries and illnesses.

Enacted by Chapter 141, 1999 General Session

26-8a-202 Emergency medical communications.

Consistent with federal law, the department is the lead agency for coordinating the statewide emergency medical service communication systems under which emergency medical personnel, dispatch centers, and treatment facilities provide medical control and coordination between emergency medical service providers.

Enacted by Chapter 141, 1999 General Session

26-8a-203 Data collection.

(1) The committee shall specify the information that shall be collected for the emergency medical services data system established pursuant to Subsection (2).
(2)
  (a) The department shall establish an emergency medical services data system which shall provide for the collection of information, as defined by the committee, relating to the treatment and care of patients who use or have used the emergency medical services system.
  (b) Beginning July 1, 2017, the committee shall coordinate with the Health Data Authority created in Chapter 33a, Utah Health Data Authority Act, to create a report of data collected by the Health Data Committee under Section 26-33a-106.1 regarding:
    (i) appropriate analytical methods;
    (ii) the total amount of air ambulance flight charges in the state for a one-year period; and
    (iii) of the total number of flights in a one-year period under Subsection (2)(b)(i):
      (A) the number of flights for which a patient had no personal responsibility for paying part of the flight charges;
      (B) the number of flights for which a patient had personal responsibility to pay all or part of the flight charges;
      (C) the range of flight charges for which patients had personal responsibility under Subsection (2)(b)(iii)(B), including the median amount for paid patient personal responsibility; and

(D) the name of any air ambulance provider that received a median paid amount for patient responsibility in excess of the median amount for all paid patient personal responsibility during the reporting year.

(3)
(a) The department shall, beginning October 1, 2017, and on or before each October 1 thereafter, make the information in Subsection (2)(b) public and send the information in Subsection (2)(b) to:
(i) the Health and Human Services Interim Committee; and
(ii) public safety dispatchers and first responders in the state.
(b) Before making the information in Subsection (2)(b) public, the committee shall provide the air ambulance providers named in the report with the opportunity to respond to the accuracy of the information in the report under Section 26-33a-107.

(4) Persons providing emergency medical services:
(a) shall provide information to the department for the emergency medical services data system established pursuant to Subsection (2)(a);
(b) are not required to provide information to the department under Subsection (2)(b); and
(c) may provide information to the department under Subsection (2)(b) or (3)(b).

Amended by Chapter 419, 2017 General Session

26-8a-204 Disaster coordination plan.

The department shall develop and implement, in cooperation with state, federal, and local agencies empowered to oversee disaster response activities, plans to provide emergency medical services during times of disaster or emergency.

Enacted by Chapter 141, 1999 General Session

26-8a-205 Pediatric quality improvement program.

The department shall establish a pediatric quality improvement resource program.

Enacted by Chapter 141, 1999 General Session

26-8a-206 Personnel stress management program.

(1) The department shall develop and implement a statewide program to provide support and counseling for personnel who have been exposed to one or more stressful incidents in the course of providing emergency services.

(2) This program shall include:
(a) ongoing training for agencies providing emergency services and counseling program volunteers; and
(b) critical incident stress debriefing for personnel at no cost to the emergency provider.

Enacted by Chapter 141, 1999 General Session

26-8a-207 Emergency medical services grant program.

(1)
(a) The department shall receive as dedicated credits the amount established in Section 51-9-403. That amount shall be transferred to the department by the Division of Finance

from funds generated by the surcharge imposed under Title 51, Chapter 9, Part 4, Criminal Conviction Surcharge Allocation.

(b) Funds transferred to the department under this section shall be used for improvement of delivery of emergency medical services and administrative costs as described in Subsection (2)(a). Appropriations to the department for the purposes enumerated in this section shall be made from those dedicated credits.

(2)

(a) The department may use the funds transferred to it under Subsection (1):

(i) to provide staff support; and

(ii) for other expenses incurred in:

(A) administration of grant funds; and

(B) other department administrative costs under this chapter.

(b) After funding staff support, administrative expenses, and trauma system development, the department and the committee shall make emergency medical services grants from the remaining funds received as dedicated credits under Subsection (1). A recipient of a grant under this Subsection (2)(b) shall actively provide emergency medical services within the state.

(c) The department shall distribute not less than 25% of the funds, with the percentage being authorized by a majority vote of the committee, as per capita block grants for use specifically related to the provision of emergency medical services to nonprofit prehospital emergency medical services providers that are either licensed or designated and to emergency medical services that are the primary emergency medical services for a service area. The department shall determine the grant amounts by prorating available funds on a per capita basis by county as described in department rule.

(d) The committee shall award the remaining funds as competitive grants for use specifically related to the provision of emergency medical services based upon rules established by the committee.

Amended by Chapter 297, 2011 General Session
Amended by Chapter 303, 2011 General Session

26-8a-208 Fees for training equipment rental, testing, and quality assurance reviews.

(1) The department may charge fees, established pursuant to Section 26-1-6:

(a) for the use of department-owned training equipment;

(b) to administer tests and conduct quality assurance reviews; and

(c) to process an application for a designation, permit, or license.

(2)

(a) Fees collected under Subsections (1)(a) and (b) shall be separate dedicated credits.

(b) Fees under Subsection (1)(a) may be used to purchase training equipment.

(c) Fees under Subsection (1)(b) may be used to administer tests and conduct quality assurance reviews.

Amended by Chapter 326, 2017 General Session

Part 2a
Statewide Trauma System

26-8a-250 Establishment of statewide trauma system.

The department shall establish and actively supervise a statewide trauma system to:

(1) promote optimal care for trauma patients;

(2) alleviate unnecessary death and disability from trauma and emergency illness;

(3) inform health care providers about trauma system capabilities;

(4) encourage the efficient and effective continuum of patient care, including prevention, prehospital care, hospital care, and rehabilitative care; and

(5) minimize the overall cost of trauma care.

Enacted by Chapter 305, 2000 General Session

26-8a-251 Trauma system advisory committee.

(1) There is created within the department the trauma system advisory committee.

(2)

(a) The committee shall be comprised of individuals knowledgeable in adult or pediatric trauma care, including physicians, physician assistants, nurses, hospital administrators, emergency medical services personnel, government officials, consumers, and persons affiliated with professional health care associations.

(b) Representation on the committee shall be broad and balanced among the health care delivery systems in the state with no more than three representatives coming from any single delivery system.

(3) The committee shall:

(a) advise the department regarding trauma system needs throughout the state;

(b) assist the department in evaluating the quality and outcomes of the overall trauma system;

(c) review and comment on proposals and rules governing the statewide trauma system; and

(d) make recommendations for the development of statewide triage, treatment, transportation, and transfer guidelines.

(4) The department shall:

(a) determine, by rule, the term and causes for removal of committee members;

(b) establish committee procedures and administration policies consistent with this chapter and department rule; and

(c) provide administrative support to the committee.

Amended by Chapter 349, 2019 General Session

26-8a-252 Department duties.

In connection with the statewide trauma system established in Section 26-8a-250, the department shall:

(1) establish a statewide trauma system plan that:

(a) identifies statewide trauma care needs, objectives, and priorities;

(b) identifies the equipment, facilities, personnel training, and other things necessary to create and maintain a statewide trauma system; and

(c) organizes and coordinates trauma care within defined geographic areas;

(2) support the statewide trauma system by:

(a) facilitating the coordination of prehospital, acute care, and rehabilitation services and providers through state regulation and oversight;

(b) facilitating the ongoing evaluation and refinement of the statewide trauma system;

(c) providing educational programs;
(d) encouraging cooperation between community organizations, health care facilities, public health officials, emergency medical service providers, and rehabilitation facilities for the development of a statewide trauma system;
(e) implementing a quality assurance program using information from the statewide trauma registry established pursuant to Section 26-8a-253;
(f) establishing trauma center designation requirements in accordance with Section 26-8a-254; and
(g) developing standards so that:
(i) trauma centers are categorized according to their capability to provide care;
(ii) trauma victims are triaged at the initial point of patient contact; and
(iii) trauma patients are sent to appropriate health care facilities.

Enacted by Chapter 305, 2000 General Session

26-8a-253 Statewide trauma registry and quality assurance program.

(1) The department shall:
(a) establish and fund a statewide trauma registry to collect and analyze information on the incidence, severity, causes, and outcomes of trauma;
(b) establish, by rule, the data elements, the medical care providers that shall report, and the time frame and format for reporting;
(c) use the data collected to:
(i) improve the availability and delivery of prehospital and hospital trauma care;
(ii) assess trauma care delivery, patient care outcomes, and compliance with the requirements of this chapter and applicable department rules; and
(iii) regularly produce and disseminate reports to data providers, state government, and the public; and
(d) support data collection and abstraction by providing:
(i) a data collection system and technical assistance to each hospital that submits data; and
(ii) funding or, at the discretion of the department, personnel for collection and abstraction for each hospital not designated as a trauma center under the standards established pursuant to Section 26-8a-254.
(2)
(a) Each hospital shall submit trauma data in accordance with rules established under Subsection (1).
(b) A hospital designated as a trauma center shall submit data as part of the ongoing quality assurance program established in Section 26-8a-252.
(3) The department shall assess:
(a) the effectiveness of the data collected pursuant to Subsection (1); and
(b) the impact of the statewide trauma system on the provision of trauma care.
(4) Data collected under this section shall be subject to Chapter 3, Health Statistics.
(5) No person may be held civilly liable for having provided data to the department in accordance with this section.

Amended by Chapter 297, 2011 General Session

26-8a-254 Trauma center designations and guidelines.

(1) The department, after seeking the advice of the trauma system advisory committee, shall establish by rule:
  (a) trauma center designation requirements; and
  (b) model state guidelines for triage, treatment, transportation, and transfer of trauma patients to the most appropriate health care facility.
(2) The department shall designate as a trauma center each hospital that:
  (a) voluntarily requests a trauma center designation; and
  (b) meets the applicable requirements established pursuant to Subsection (1).

Enacted by Chapter 305, 2000 General Session

Part 3
Certificates, Designations, Permits, and Licenses

26-8a-301 General requirement.
(1) Except as provided in Section 26-8a-308 or 26-8b-201:
  (a) an individual may not provide emergency medical services without a license issued under Section 26-8a-302;
  (b) a facility or provider may not hold itself out as a designated emergency medical service provider or nonemergency secured behavioral health transport provider without a designation issued under Section 26-8a-303;
  (c) a vehicle may not operate as an ambulance, emergency response vehicle, or nonemergency secured behavioral health transport vehicle without a permit issued under Section 26-8a-304; and
  (d) an entity may not respond as an ambulance or paramedic provider without the appropriate license issued under Part 4, Ambulance and Paramedic Providers.
(2) Section 26-8a-502 applies to violations of this section.

Amended by Chapter 265, 2019 General Session

26-8a-302 Licensure of emergency medical service personnel.
(1) To promote the availability of comprehensive emergency medical services throughout the state, the committee shall establish:
  (a) initial and ongoing licensure and training requirements for emergency medical service personnel in the following categories:
    (i) paramedic;
    (ii) medical director;
    (iii) emergency medical service instructor; and
    (iv) other types of emergency medical personnel as the committee considers necessary; and
  (b) guidelines for giving credit for out-of-state training and experience.
(2) The department shall, based on the requirements established in Subsection (1):
  (a) develop, conduct, and authorize training and testing for emergency medical service personnel; and
  (b) issue a license and license renewals to emergency medical service personnel.
(3) As provided in Section 26-8a-502, an individual issued a license under this section may only provide emergency medical services to the extent allowed by the license.

(4) An individual may not be issued or retain a license under this section unless the individual obtains and retains background clearance under Section 26-8a-310.

Amended by Chapter 326, 2017 General Session

26-8a-303 Designation of emergency medical service providers and nonemergency secured behavioral health transport providers.

(1) To ensure quality emergency medical services, the committee shall establish designation requirements for:
  (a) emergency medical service providers in the following categories:
    (i) quick response provider;
    (ii) resource hospital for emergency medical providers;
    (iii) emergency medical service dispatch center;
    (iv) emergency patient receiving facilities; and
    (v) other types of emergency medical service providers as the committee considers necessary; and
  (b) nonemergency secured behavioral health transport providers.
(2) The department shall, based on the requirements in Subsection (1), issue designations to emergency medical service providers and nonemergency secured behavioral health transport providers listed in Subsection (1).
(3) As provided in Section 26-8a-502, an entity issued a designation under Subsection (2) may only function and hold itself out in accordance with its designation.

Amended by Chapter 265, 2019 General Session

26-8a-304 Permits for emergency medical service vehicles and nonemergency secured behavioral health transport vehicles.

(1)
  (a) To ensure that emergency medical service vehicles and nonemergency secured behavioral health transport vehicles are adequately staffed, safe, maintained, properly equipped, and safely operated, the committee shall establish permit requirements at levels it considers appropriate in the following categories:
    (i) ambulance;
    (ii) emergency medical response vehicle; and
    (iii) nonemergency secured behavioral health transport vehicle.
  (b) The permit requirements under Subsections (1)(a)(i) and (ii) shall include a requirement that beginning on or after January 31, 2014, every operator of an ambulance or emergency medical response vehicle annually provide proof of the successful completion of an emergency vehicle operator's course approved by the department for all ambulances and emergency medical response vehicle operators.
(2) The department shall, based on the requirements established in Subsection (1), issue permits to emergency medical service vehicles and nonemergency secured behavioral health transport vehicles.

Amended by Chapter 265, 2019 General Session

26-8a-305 Ambulance license required for emergency medical transport.

Except as provided in Section 26-8a-308, only an ambulance operating under a permit issued under Section 26-8a-304 may transport an individual who:
(1) is in an emergency medical condition;
(2) is medically or mentally unstable, requiring direct medical observation during transport;
(3) is physically incapacitated because of illness or injury and in need of immediate transport by emergency medical service personnel;
(4) is likely to require medical attention during transport;
(5) is being maintained on any type of emergency medical electronic monitoring;
(6) is receiving or has recently received medications that could cause a sudden change in medical condition that might require emergency medical services;
(7) requires IV administration or maintenance, oxygen that is not patient-operated, or other emergency medical services during transport;
(8) needs to be immobilized during transport to a hospital, an emergency patient receiving facility, or mental health facility due to a mental or physical condition, unless the individual is in the custody of a peace officer and the primary purpose of the restraint is to prevent escape;
(9) needs to be immobilized due to a fracture, possible fracture, or other medical condition; or
(10) otherwise requires or has the potential to require a level of medical care that the committee establishes as requiring direct medical observation.

Enacted by Chapter 141, 1999 General Session

26-8a-306 Medical control.
(1) The committee shall establish requirements for the coordination of emergency medical services rendered by emergency medical service providers, including the coordination between prehospital providers, hospitals, emergency patient receiving facilities, and other appropriate destinations.
(2) The committee may establish requirements for the medical supervision of emergency medical service providers to assure adequate physician oversight of emergency medical services and quality improvement.

Enacted by Chapter 141, 1999 General Session

26-8a-307 Patient destination.
(1) If an individual being transported by a ground or air ambulance is in critical or unstable condition, the ground or air ambulance shall transport the patient to the trauma center or closest emergency patient receiving facility appropriate to adequately treat the patient.
(2) If the patient's condition is not critical or unstable as determined by medical control, the ground or air ambulance may transport the patient to the:
  (a) hospital, emergency patient receiving facility, or other medical provider chosen by the patient and approved by medical control as appropriate for the patient's condition and needs; or
  (b) nearest hospital, emergency patient receiving facility, or other medical provider approved by medical control as appropriate for the patient's condition and needs if the patient expresses no preference.

Enacted by Chapter 141, 1999 General Session

26-8a-308 Exemptions.

(1) The following persons may provide emergency medical services to a patient without being licensed under this chapter:
  (a) out-of-state emergency medical service personnel and providers in time of disaster;
  (b) an individual who gratuitously acts as a Good Samaritan;
  (c) a family member;
  (d) a private business if emergency medical services are provided only to employees at the place of business and during transport;
  (e) an agency of the United States government if compliance with this chapter would be inconsistent with federal law; and
  (f) police, fire, and other public service personnel if:
    (i) emergency medical services are rendered in the normal course of the person's duties; and
    (ii) medical control, after being apprised of the circumstances, directs immediate transport.
(2) An ambulance or emergency response vehicle may operate without a permit issued under Section 26-8a-304 in time of disaster.
(3) Nothing in this chapter or Title 58, Occupations and Professions, may be construed as requiring a license for an individual to administer cardiopulmonary resuscitation or to use a fully automated external defibrillator under Section 26-8b-201.
(4) Nothing in this chapter may be construed as requiring a license, permit, or designation for an acute care hospital, medical clinic, physician's office, or other fixed medical facility that:
  (a) is staffed by a physician, physician's assistant, nurse practitioner, or registered nurse; and
  (b) treats an individual who has presented himself or was transported to the hospital, clinic, office, or facility.

Amended by Chapter 326, 2017 General Session

26-8a-309 Out-of-state vehicles.
(1) An ambulance or emergency response vehicle from another state may not pick up a patient in Utah to transport that patient to another location in Utah or to another state without a permit issued under Section 26-8a-304 and, in the case of an ambulance, a license issued under Part 4, Ambulance and Paramedic Providers.
(2) Notwithstanding Subsection (1), an ambulance or emergency response vehicle from another state may, without a permit or license:
  (a) transport a patient into Utah; and
  (b) provide assistance in time of disaster.
(3) The department may enter into agreements with ambulance and paramedic providers and their respective licensing agencies from other states to assure the expeditious delivery of emergency medical services beyond what may be reasonably provided by licensed ambulance and paramedic providers, including the transportation of patients between states.

Enacted by Chapter 141, 1999 General Session

26-8a-310 Background clearance for emergency medical service personnel.
(1) The department shall determine whether to grant background clearance for an individual seeking licensure under Section 26-8a-302 from whom it receives:
  (a) the individual's social security number, fingerprints, and other personal identification information specified by the department under Subsection (4); and
  (b) any fees established by the department under Subsection (10).

(2) The department shall determine whether to deny or revoke background clearance for individuals for whom it has previously granted background clearance.
(3) The department shall determine whether to grant, deny, or revoke background clearance for an individual based on an initial and ongoing evaluation of information the department obtains under Subsections (5) and (11), which, at a minimum, shall include an initial criminal background check of state, regional, and national databases using the individual's fingerprints.
(4) The department shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that specify:
  (a) the criteria the department will use under Subsection (3) to determine whether to grant, deny, or revoke background clearance; and
  (b) the other personal identification information an individual seeking licensure under Section 26-8a-302 must submit under Subsection (1).
(5) To determine whether to grant, deny, or revoke background clearance, the department may access and evaluate any of the following:
  (a) Department of Public Safety arrest, conviction, and disposition records described in Title 53, Chapter 10, Criminal Investigations and Technical Services Act, including information in state, regional, and national records files;
  (b) adjudications by a juvenile court of committing an act that if committed by an adult would be a felony or misdemeanor, if:
    (i) the applicant is under 28 years of age; or
    (ii) the applicant:
      (A) is over 28 years of age; and
      (B) has been convicted of, has pleaded no contest to, or is currently subject to a plea in abeyance or diversion agreement for a felony or misdemeanor;
  (c) juvenile court arrest, adjudication, and disposition records, other than those under Subsection (5)(b), as allowed under Section 78A-6-209;
  (d) child abuse or neglect findings described in Section 78A-6-323;
  (e) the Department of Human Services' Division of Child and Family Services Licensing Information System described in Section 62A-4a-1006;
  (f) the Department of Human Services' Division of Aging and Adult Services database of reports of vulnerable adult abuse, neglect, or exploitation, described in Section 62A-3-311.1;
  (g) Division of Occupational and Professional Licensing records of licensing and certification under Title 58, Occupations and Professions;
  (h) records in other federal criminal background databases available to the state; and
  (i) any other records of arrests, warrants for arrest, convictions, pleas in abeyance, pending diversion agreements, or dispositions.
(6) Except for the Department of Public Safety, an agency may not charge the department for information accessed under Subsection (5).
(7) When evaluating information under Subsection (3), the department shall classify a crime committed in another state according to the closest matching crime under Utah law, regardless of how the crime is classified in the state where the crime was committed.
(8) The department shall adopt measures to protect the security of information it accesses under Subsection (5), which shall include limiting access by department employees to those responsible for acquiring, evaluating, or otherwise processing the information.
(9) The department may disclose personal identification information it receives under Subsection (1) to the Department of Human Services to verify that the subject of the information is not identified as a perpetrator or offender in the information sources described in Subsections (5)(d) through (f).

(10) The department may charge fees, in accordance with Section 63J-1-504, to pay for:
(a) the cost of obtaining, storing, and evaluating information needed under Subsection (3), both initially and on an ongoing basis, to determine whether to grant, deny, or revoke background clearance; and
(b) other department costs related to granting, denying, or revoking background clearance.
(11) The Criminal Investigations and Technical Services Division within the Department of Public Safety shall:
(a) retain, separate from other division records, personal information under Subsection (1), including any fingerprints sent to it by the Department of Health; and
(b) notify the Department of Health upon receiving notice that an individual for whom personal information has been retained is the subject of:
(i) a warrant for arrest;
(ii) an arrest;
(iii) a conviction, including a plea in abeyance; or
(iv) a pending diversion agreement.
(12) The department shall use the Direct Access Clearance System database created under Section 26-21-209 to manage information about the background clearance status of each individual for whom the department is required to make a determination under Subsection (1).

Amended by Chapter 326, 2017 General Session

Part 4
Ambulance and Paramedic Providers

26-8a-401 State regulation of emergency medical services market.
(1) To ensure emergency medical service quality and minimize unnecessary duplication, the department shall regulate the emergency medical service market after October 1, 1999, by creating and operating a statewide system that:
(a) consists of exclusive geographic service areas as provided in Section 26-8a-402; and
(b) establishes maximum rates as provided in Section 26-8a-403.
(2)
(a) All licenses issued prior to July 1, 1996, shall expire as stated in the license.
(b) If no expiration date is stated on a license issued before July 1, 1996, the license shall expire on October 1, 1999, unless:
(i) the license holder requests agency action before August 1, 1999; and
(ii) before October 1, 1999, the department:
(A) finds the license has been used as the basis for responding to requests for ambulance or paramedic services during the past five years;
(B) identifies one or more specific geographic areas covered by the license in which the license holder has actively and adequately responded as the primary provider to requests for ambulance or paramedic services during the past five years; and
(C) determines that the continuation of a license in a specific geographic area identified in Subsection (2)(b)(ii)(B) satisfies:
(I) the standards established pursuant to Subsection 26-8a-404(2); and
(II) the requirement of public convenience and necessity.

(c) If the department finds that a license meets the requirements of Subsection (2)(b), the department shall amend the license to reflect:
(i) the specific geographic area of the license; and
(ii) a four-year term extension.
(d) Before July 1, 1999, the department shall publish notice once a week for four consecutive weeks of the expiration of licenses pursuant to Subsection (2)(b) in a newspaper of general circulation in the state.
(e) Nothing in this Subsection (2) may be construed as restricting the authority of the department to amend overlapping licenses pursuant to Section 26-8a-416.
(3) After October 1, 1999, new licenses and license renewals shall be for a four-year term.

Enacted by Chapter 141, 1999 General Session

26-8a-402 Exclusive geographic service areas.
(1) Each ground ambulance provider license issued under this part shall be for an exclusive geographic service area as described in the license. Only the licensed ground ambulance provider may respond to an ambulance request that originates within the provider's exclusive geographic service area, except as provided in Subsection (5) and Section 26-8a-416.
(2) Each paramedic provider license issued under this part shall be for an exclusive geographic service area as described in the license. Only the licensed paramedic provider may respond to a paramedic request that originates within the exclusive geographic service area, except as provided in Subsection (6) and Section 26-8a-416.
(3) Nothing in this section may be construed as either requiring or prohibiting that the formation of boundaries in a given location be the same for a licensed paramedic provider as it is for a licensed ambulance provider.
(4)
(a) A licensed ground ambulance or paramedic provider may, as necessary, enter into a mutual aid agreement to allow another licensed provider to give assistance in times of unusual demand, as that term is defined by the committee in rule.
(b) A mutual aid agreement shall include a formal written plan detailing the type of assistance and the circumstances under which it would be given.
(c) The parties to a mutual aid agreement shall submit a copy of the agreement to the department.
(d) Notwithstanding this Subsection (4), a licensed provider may not subcontract with another entity to provide services in the licensed provider's exclusive geographic service area.
(5) Notwithstanding Subsection (1), a licensed ground ambulance provider may respond to an ambulance request that originates from the exclusive geographic area of another provider:
(a) pursuant to a mutual aid agreement;
(b) to render assistance on a case-by-case basis to that provider; and
(c) as necessary to meet needs in time of disaster or other major emergency.
(6) Notwithstanding Subsection (2), a licensed paramedic provider may respond to a paramedic request that originates from the exclusive geographic area of another provider:
(a) pursuant to a mutual aid agreement;
(b) to render assistance on a case-by-case basis to that provider; and
(c) as necessary to meet needs in time of disaster or other major emergency.

Amended by Chapter 1, 2000 General Session

26-8a-403 Establishment of maximum rates.

(1) The department shall, after receiving recommendations under Subsection (2), establish maximum rates for ground ambulance providers and paramedic providers that are just and reasonable.

(2) The committee may make recommendations to the department on the maximum rates that should be set under Subsection (1).

(3)

(a) The department shall prohibit ground ambulance providers and paramedic providers from charging fees for transporting a patient when the provider does not transport the patient.

(b) The provisions of Subsection (3)(a) do not apply to ambulance providers or paramedic providers in a geographic service area which contains a town as defined in Subsection 10-2-301(2)(f).

Amended by Chapter 209, 2006 General Session

26-8a-404 Ground ambulance and paramedic licenses -- Application and department review.

(1) Except as provided in Section 26-8a-413, an applicant for a ground ambulance or paramedic license shall apply to the department for a license only by:

(a) submitting a completed application;

(b) providing information in the format required by the department; and

(c) paying the required fees, including the cost of the hearing officer.

(2) The department shall make rules establishing minimum qualifications and requirements for:

(a) personnel;

(b) capital reserves;

(c) equipment;

(d) a business plan;

(e) operational procedures;

(f) medical direction agreements;

(g) management and control; and

(h) other matters that may be relevant to an applicant's ability to provide ground ambulance or paramedic service.

(3) An application for a license to provide ground ambulance service or paramedic service shall be for all ground ambulance services or paramedic services arising within the geographic service area, except that an applicant may apply for a license for less than all ground ambulance services or all paramedic services arising within an exclusive geographic area if it can demonstrate how the remainder of that area will be served.

(4)

(a) A ground ambulance service licensee may apply to the department for a license to provide a higher level of service as defined by department rule if the application includes:

(i) a copy of the new treatment protocols for the higher level of service approved by the off-line medical director;

(ii) an assessment of field performance by the applicant's off-line director; and

(iii) an updated plan of operation demonstrating the ability of the applicant to provide the higher level of service.

(b) If the department determines that the applicant has demonstrated the ability to provide the higher level of service in accordance with Subsection (4)(a), the department shall issue a revised license reflecting the higher level of service and the requirements of Section 26-8a-408 do not apply.

(c) A revised license issued under Subsection (4)(b):
(i) may only affect the level of service that the licensee may provide;
(ii) may not affect any other terms, conditions, or limitations of the original license; and
(iii) may not impact the rights of other licensees.
(5) Upon receiving a completed application and the required fees, the department shall review the application and determine whether the application meets the minimum qualifications and requirements for licensure.
(6) The department may deny an application if it finds that it contains any materially false or misleading information, is incomplete, or if the application demonstrates that the applicant fails to meet the minimum qualifications and requirements for licensure under Subsection (2).
(7) If the department denies an application, it shall notify the applicant in writing setting forth the grounds for the denial. A denial may be appealed under Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 390, 2019 General Session

26-8a-405 Ground ambulance and paramedic licenses -- Agency notice of approval.
(1) Beginning January 1, 2004, if the department determines that the application meets the minimum requirements for licensure under Section 26-8a-404, the department shall issue a notice of the approved application to the applicant.
(2) A current license holder responding to a request for proposal under Section 26-8a-405.2 is considered an approved applicant for purposes of Section 26-8a-405.2 if the current license holder, prior to responding to the request for proposal, submits the following to the department:
(a) the information described in Subsections 26-8a-404(4)(a)(i) through (iii); and
(b)
(i) if the license holder is a private entity, a financial statement, a pro forma budget and necessary letters of credit demonstrating a financial ability to expand service to a new service area; or
(ii) if the license holder is a governmental entity, a letter from the governmental entity's governing body demonstrating the governing body's willingness to financially support the application.

Amended by Chapter 390, 2019 General Session

26-8a-405.1 Selection of provider by political subdivision.
(1)
(a) Only an applicant approved under Section 26-8a-405 may respond to a request for a proposal issued in accordance with Section 26-8a-405.2 or Section 26-8a-405.4 by a political subdivision.
(b) A response to a request for proposal is subject to the maximum rates established by the department under Section 26-8a-403.
(c) A political subdivision may award a contract to an applicant in response to a request for proposal:
(i) in accordance with Section 26-8a-405.2; and
(ii) subject to Subsection (2).
(2)

(a) The department shall issue a license to an applicant selected by a political subdivision under Subsection (1) unless the department finds that issuing a license to that applicant would jeopardize the health, safety, and welfare of the citizens of the geographic service area.
(b) A license issued under this Subsection (2):
(i) is for the exclusive geographic service area approved by the department in accordance with Subsection 26-8a-405.2(2);
(ii) is valid for four years;
(iii) is not subject to a request for license from another applicant under the provisions of Sections 26-8a-406 through 26-8a-409 during the four-year term, unless the applicant's license is revoked under Section 26-8a-504; and
(iv) is subject to supervision by the department under Sections 26-8a-503 and 26-8a-504.
(3) Except as provided in Subsection 26-8a-405.3(4)(a), the provisions of Sections 26-8a-406 through 26-8a-409 do not apply to a license issued under this section.

Amended by Chapter 187, 2010 General Session

26-8a-405.2 Selection of provider -- Request for competitive sealed proposal -- Public convenience and necessity.
(1)
(a) A political subdivision may contract with an applicant approved under Section 26-8a-404 to provide services for the geographic service area that is approved by the department in accordance with Subsection (2), if:
(i) the political subdivision complies with the provisions of this section and Section 26-8a-405.3 if the contract is for 911 ambulance or paramedic services; or
(ii) the political subdivision complies with Sections 26-8a-405.3 and 26-8a-405.4, if the contract is for non-911 services.
(b)
(i) The provisions of this section and Sections 26-8a-405.1, 26-8a-405.3, and 26-8a-405.4 do not require a political subdivision to issue a request for proposal for ambulance or paramedic services or non-911 services.
(ii) If a political subdivision does not contract with an applicant in accordance with this section and Section 26-8a-405.3, the provisions of Sections 26-8a-406 through 26-8a-409 apply to the issuance of a license for ambulance or paramedic services in the geographic service area that is within the boundaries of the political subdivision.
(iii) If a political subdivision does not contract with an applicant in accordance with this section, Section 26-8a-405.3 and Section 26-8a-405.4, a license for the non-911 services in the geographic service area that is within the boundaries of the political subdivision may be issued:
(A) under the public convenience and necessity provisions of Sections 26-8a-406 through 26-8a-409; or
(B) by a request for proposal issued by the department under Section 26-8a-405.5.
(c)
(i) For purposes of this Subsection (1)(c):
(A) "Fire district" means a local district under Title 17B, Limited Purpose Local Government Entities - Local Districts, that:
(I) is located in a county of the first or second class; and
(II) provides fire protection, paramedic, and emergency services.

(B) "Participating municipality" means a city or town whose area is partly or entirely included within a county service area or fire district.
(C) "Participating county" means a county whose unincorporated area is partly or entirely included within a fire district.
(ii) A participating municipality or participating county may as provided in this section and Section 26-8a-405.3, contract with a provider for 911 ambulance or paramedic service.
(iii) If the participating municipality or participating county contracts with a provider for services under this section and Section 26-8a-405.3:
(A) the fire district is not obligated to provide the services that are included in the contract between the participating municipality or the participating county and the provider;
(B) the fire district may impose taxes and obligations within the fire district in the same manner as if the participating municipality or participating county were receiving all services offered by the fire district; and
(C) the participating municipality's and participating county's obligations to the fire district are not diminished.

(2)
(a) The political subdivision shall submit the request for proposal and the exclusive geographic service area to be included in a request for proposal issued under Subsections (1)(a)(i) or (ii) to the department for approval prior to issuing the request for proposal. The department shall approve the request for proposal and the exclusive geographic service area:
(i) unless the geographic service area creates an orphaned area; and
(ii) in accordance with Subsections (2)(b) and (c).
(b) The exclusive geographic service area may:
(i) include the entire geographic service area that is within the political subdivision's boundaries;
(ii) include islands within or adjacent to other peripheral areas not included in the political subdivision that governs the geographic service area; or
(iii) exclude portions of the geographic service area within the political subdivision's boundaries if another political subdivision or licensed provider agrees to include the excluded area within their license.
(c) The proposed geographic service area for 911 ambulance or paramedic service shall demonstrate that non-911 ambulance or paramedic service will be provided in the geographic service area, either by the current provider, the applicant, or some other method acceptable to the department. The department may consider the effect of the proposed geographic service area on the costs to the non-911 provider and that provider's ability to provide only non-911 services in the proposed area.

Amended by Chapter 297, 2011 General Session

26-8a-405.3 Use of competitive sealed proposals -- Procedure -- Appeal rights.

(1)
(a) Competitive sealed proposals for paramedic or 911 ambulance services under Section 26-8a-405.2, or for non-911 services under Section 26-8a-405.4, shall be solicited through a request for proposal and the provisions of this section.
(b) The governing body of the political subdivision shall approve the request for proposal prior to the notice of the request for proposals under Subsection (1)(c).
(c)
(i) Notice of the request for proposals shall be published:

(A) at least once a week for three consecutive weeks in a newspaper of general circulation published in the county; or

(B) if there is no such newspaper, then notice shall be posted for at least 20 days in at least five public places in the county; and

(ii) in accordance with Section 45-1-101 for at least 20 days.

(2)

(a) Proposals shall be opened so as to avoid disclosure of contents to competing offerors during the process of negotiations.

(b)

(i) Subsequent to the published notice, and prior to selecting an applicant, the political subdivision shall hold a presubmission conference with interested applicants for the purpose of assuring full understanding of, and responsiveness to, solicitation requirements.

(ii) A political subdivision shall allow at least 90 days from the presubmission conference for the proposers to submit proposals.

(c) Subsequent to the presubmission conference, the political subdivision may issue addenda to the request for proposals. An addenda to a request for proposal shall be finalized and posted by the political subdivision at least 45 days before the day on which the proposal must be submitted.

(d) Offerors to the request for proposals shall be accorded fair and equal treatment with respect to any opportunity for discussion and revisions of proposals, and revisions may be permitted after submission and before a contract is awarded for the purpose of obtaining best and final offers.

(e) In conducting discussions, there shall be no disclosures of any information derived from proposals submitted by competing offerors.

(3)

(a)

(i) A political subdivision may select an applicant approved by the department under Section 26-8a-404 to provide 911 ambulance or paramedic services by contract to the most responsible offeror as defined in Section 63G-6a-103.

(ii) An award under Subsection (3)(a)(i) shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the political subdivision, taking into consideration price and the evaluation factors set forth in the request for proposal.

(b) The applicants who are approved under Section 26-8a-405 and who are selected under this section may be the political subdivision issuing the request for competitive sealed proposals, or any other public entity or entities, any private person or entity, or any combination thereof.

(c) A political subdivision may reject all of the competitive proposals.

(4) In seeking competitive sealed proposals and awarding contracts under this section, a political subdivision:

(a) shall apply the public convenience and necessity factors listed in Subsections 26-8a-408(2) through (6);

(b) shall require the applicant responding to the proposal to disclose how the applicant will meet performance standards in the request for proposal;

(c) may not require or restrict an applicant to a certain method of meeting the performance standards, including:

(i) requiring ambulance medical personnel to also be a firefighter; or

(ii) mandating that offerors use fire stations or dispatch services of the political subdivision;

(d) shall require an applicant to submit the proposal:

(i) based on full cost accounting in accordance with generally accepted accounting principals; and
(ii) if the applicant is a governmental entity, in addition to the requirements of Subsection (4)(e)(i), in accordance with generally accepted government auditing standards and in compliance with the State of Utah Legal Compliance Audit Guide; and
(e) shall set forth in the request for proposal:
(i) the method for determining full cost accounting in accordance with generally accepted accounting principles, and require an applicant to submit the proposal based on such full cost accounting principles;
(ii) guidelines established to further competition and provider accountability; and
(iii) a list of the factors that will be considered by the political subdivision in the award of the contract, including by percentage, the relative weight of the factors established under this Subsection (4)(e), which may include such things as:
(A) response times;
(B) staging locations;
(C) experience;
(D) quality of care; and
(E) cost, consistent with the cost accounting method in Subsection (4)(e)(i).
(5)
(a) Notwithstanding any provision of Title 63G, Chapter 6a, Utah Procurement Code, to the contrary, the provisions of Title 63G, Chapter 6a, Utah Procurement Code, apply to the procurement process required by this section, except as provided in Subsection (5)(c).
(b) A procurement appeals panel described in Section 63G-6a-1702 shall have jurisdiction to review and determine an appeal of an offeror under this section.
(c)
(i) An offeror may appeal the solicitation or award as provided by the political subdivision's procedures. After all political subdivision appeal rights are exhausted, the offeror may appeal under the provisions of Subsections (5)(a) and (b).
(ii) A procurement appeals panel described in Section 63G-6a-1702 shall determine whether the solicitation or award was made in accordance with the procedures set forth in this section and Section 26-8a-405.2.
(d) The determination of an issue of fact by the appeals board shall be final and conclusive unless arbitrary and capricious or clearly erroneous as provided in Section 63G-6a-1705.

Amended by Chapter 91, 2012 General Session
Amended by Chapter 347, 2012 General Session
Amended by Chapter 347, 2012 General Session, (Coordination Clause)

26-8a-405.4 Non-911 provider -- Finding of meritorious complaint -- Request for proposals.
(1) Notwithstanding Subsection 26-8a-102(18), for purposes of this section, political subdivision includes:
(a) a county of any class; and
(b) a city or town located in a county of any class.
(2)
(a) This section applies to a non-911 provider license under this chapter.
(b) The department shall, in accordance with Subsections (4) and (5):
(i) receive a complaint about a non-911 provider;
(ii) determine whether the complaint has merit;

(iii) issue a finding of:
(A) a meritorious complaint; or
(B) a non-meritorious complaint; and
(iv) forward a finding of a meritorious complaint to the governing body of the political subdivision:
(A) in which the non-911 provider is licensed; or
(B) that provides the non-911 services, if different from Subsection (2)(b)(iv)(A).

(3)
(a) A political subdivision that receives a finding of a meritorious complaint from the department:
(i) shall take corrective action that the political subdivision determines is appropriate; and
(ii) shall, if the political subdivision determines corrective action will not resolve the complaint or is not appropriate:
(A) issue a request for proposal for non-911 service in the geographic service area if the political subdivision will not respond to the request for proposal; or
(B)
(I) make a finding that a request for proposal for non-911 services is appropriate and the political subdivision intends to respond to a request for proposal; and
(II) submit the political subdivision's findings to the department with a request that the department issue a request for proposal in accordance with Section 26-8a-405.5.

(b)
(i) If Subsection (3)(a)(ii)(A) applies, the political subdivision shall issue the request for proposal in accordance with Sections 26-8a-405.1 through 26-8a-405.3.
(ii) If Subsection (3)(a)(ii)(B) applies, the department shall issue a request for proposal for non-911 services in accordance with Section 26-8a-405.5.

(4) The department shall make a determination under Subsection (2)(b) if:
(a) the department receives a written complaint from any of the following in the geographic service area:
(i) a hospital;
(ii) a health care facility;
(iii) a political subdivision; or
(iv) an individual; and
(b) the department determines, in accordance with Subsection (2)(b), that the complaint has merit.

(5)
(a) If the department receives a complaint under Subsection (2)(b), the department shall request a written response from the non-911 provider concerning the complaint.
(b) The department shall make a determination under Subsection (2)(b) based on:
(i) the written response from the non-911 provider; and
(ii) other information that the department may have concerning the quality of service of the non-911 provider.

(c)
(i) The department's determination under Subsection (2)(b) is not subject to an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act.
(ii) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of Subsection (2)(b).

Amended by Chapter 265, 2019 General Session

26-8a-405.5 Use of competitive sealed proposals -- Procedure -- Appeal rights.

(1)

(a) The department shall issue a request for proposal for non-911 services in a geographic service area if the department receives a request from a political subdivision under Subsection 26-8a-405.4(3)(a)(ii)(B) to issue a request for proposal for non-911 services.

(b) Competitive sealed proposals for non-911 services under Subsection (1)(a) shall be solicited through a request for proposal and the provisions of this section.

(c)

(i) Notice of the request for proposals shall be published:

(A) at least once a week for three consecutive weeks in a newspaper of general circulation published in the county; or

(B) if there is no such newspaper, then notice shall be posted for at least 20 days in at least five public places in the county; and

(ii) in accordance with Section 45-1-101 for at least 20 days.

(2)

(a) Proposals shall be opened so as to avoid disclosure of contents to competing offerors during the process of negotiations.

(b)

(i) Subsequent to the published notice, and prior to selecting an applicant, the department shall hold a presubmission conference with interested applicants for the purpose of assuring full understanding of, and responsiveness to, solicitation requirements.

(ii) The department shall allow at least 90 days from the presubmission conference for the proposers to submit proposals.

(c) Subsequent to the presubmission conference, the department may issue addenda to the request for proposals. An addenda to a request for proposal shall be finalized and posted by the department at least 45 days before the day on which the proposal must be submitted.

(d) Offerors to the request for proposals shall be accorded fair and equal treatment with respect to any opportunity for discussion and revisions of proposals, and revisions may be permitted after submission and before a contract is awarded for the purpose of obtaining best and final offers.

(e) In conducting discussions, there shall be no disclosures of any information derived from proposals submitted by competing offerors.

(3)

(a)

(i) The department may select an applicant approved by the department under Section 26-8a-404 to provide non-911 services by contract to the most responsible offeror as defined in Section 63G-6a-103.

(ii) An award under Subsection (3)(a)(i) shall be made to the responsible offeror whose proposal is determined in writing to be the most advantageous to the public, taking into consideration price and the evaluation factors set forth in the request for proposal.

(b) The applicants who are approved under Section 26-8a-405 and who are selected under this section may be the political subdivision responding to the request for competitive sealed proposals, or any other public entity or entities, any private person or entity, or any combination thereof.

(c) The department may reject all of the competitive proposals.

(4) In seeking competitive sealed proposals and awarding contracts under this section, the department:

(a) shall consider the public convenience and necessity factors listed in Subsections 26-8a-408(2) through (6);
(b) shall require the applicant responding to the proposal to disclose how the applicant will meet performance standards in the request for proposal;
(c) may not require or restrict an applicant to a certain method of meeting the performance standards, including:
(i) requiring ambulance medical personnel to also be a firefighter; or
(ii) mandating that offerors use fire stations or dispatch services of the political subdivision;
(d) shall require an applicant to submit the proposal:
(i) based on full cost accounting in accordance with generally accepted accounting principals; and
(ii) if the applicant is a governmental entity, in addition to the requirements of Subsection (4)(e)(i), in accordance with generally accepted government auditing standards and in compliance with the State of Utah Legal Compliance Audit Guide; and
(e) shall set forth in the request for proposal:
(i) the method for determining full cost accounting in accordance with generally accepted accounting principles, and require an applicant to submit the proposal based on such full cost accounting principles;
(ii) guidelines established to further competition and provider accountability; and
(iii) a list of the factors that will be considered by the department in the award of the contract, including by percentage, the relative weight of the factors established under this Subsection (4)(e), which may include such things as:
(A) response times;
(B) staging locations;
(C) experience;
(D) quality of care; and
(E) cost, consistent with the cost accounting method in Subsection (4)(e)(i).
(5) A license issued under this section:
(a) is for the exclusive geographic service area approved by the department;
(b) is valid for four years;
(c) is not subject to a request for license from another applicant under the provisions of Sections 26-8a-406 through 26-8a-409 during the four-year term, unless the applicant's license is revoked under Section 26-8a-504;
(d) is subject to supervision by the department under Sections 26-8a-503 and 26-8a-504; and
(e) except as provided in Subsection (4)(a), is not subject to the provisions of Sections 26-8a-406 through 26-8a-409.

Amended by Chapter 347, 2012 General Session

26-8a-406 Ground ambulance and paramedic licenses -- Parties.
(1) When an applicant approved under Section 26-8a-404 seeks licensure under the provisions of Sections 26-8a-406 through 26-8a-409, the department shall:
(a) issue a notice of agency action to the applicant to commence an informal administrative proceeding;
(b) provide notice of the application to all interested parties; and
(c) publish notice of the application, at the applicant's expense:
(i) once a week for four consecutive weeks, in a newspaper of general circulation in the geographic service area that is the subject of the application; and

(ii) in accordance with Section 45-1-101 for four weeks.
(2) An interested party has 30 days to object to an application.
(3) If an interested party objects, the presiding officer shall join the interested party as an indispensable party to the proceeding.
(4) The department may join the proceeding as a party to represent the public interest.
(5) Others who may be affected by the grant of a license to the applicant may join the proceeding, if the presiding officer determines that they meet the requirement of legal standing.

Amended by Chapter 297, 2011 General Session

26-8a-407 Ground ambulance and paramedic licenses -- Proceedings.
(1) The presiding officer shall:
(a) commence an informal adjudicative proceeding within 120 days of receiving a completed application;
(b) meet with the applicant and objecting interested parties and provide no less than 120 days for a negotiated resolution, consistent with the criteria in Section 26-8a-408;
(c) set aside a separate time during the proceedings to accept public comment on the application; and
(d) present a written decision to the executive director if a resolution has been reached that satisfies the criteria in Section 26-8a-408.
(2) At any time during an informal adjudicative proceeding under Subsection (1), any party may request conversion of the informal adjudicative proceeding to a formal adjudicative proceeding in accordance with Section 63G-4-202.
(3) Upon conversion to a formal adjudicative proceeding, a hearing officer shall be assigned to the application as provided in Section 26-8a-409. The hearing office shall:
(a) set aside a separate time during the proceedings to accept public comment on the application;
(b) apply the criteria established in Section 26-8a-408; and
(c) present a recommended decision to the executive director in writing.
(4) The executive director may, as set forth in a final written order, accept, modify, reject, or remand the decision of a presiding or hearing officer after:
(a) reviewing the record;
(b) giving due deference to the officer's decision; and
(c) determining whether the criteria in Section 26-8a-408 have been satisfied.

Amended by Chapter 382, 2008 General Session

26-8a-408 Criteria for determining public convenience and necessity.
(1) The criteria for determining public convenience and necessity is set forth in Subsections (2) through (6).
(2) Access to emergency medical services shall be maintained or improved. The officer shall consider the impact on existing services, including the impact on response times, call volumes, populations and exclusive geographic service areas served, and the ability of surrounding licensed providers to service their exclusive geographic service areas. The issuance or amendment of a license may not create an orphaned area.
(3) The quality of service in the area shall be maintained or improved. The officer shall consider the:
(a) staffing and equipment standards of the current licensed provider and the applicant;

(b) training and licensure levels of the current licensed provider's staff and the applicant's staff;
(c) continuing medical education provided by the current licensed provider and the applicant;
(d) levels of care as defined by department rule;
(e) plan of medical control; and
(f) the negative or beneficial impact on the regional emergency medical service system to provide service to the public.

(4) The cost to the public shall be justified. The officer shall consider:
(a) the financial solvency of the applicant;
(b) the applicant's ability to provide services within the rates established under Section 26-8a-403;
(c) the applicant's ability to comply with cost reporting requirements;
(d) the cost efficiency of the applicant; and
(e) the cost effect of the application on the public, interested parties, and the emergency medical services system.

(5) Local desires concerning cost, quality, and access shall be considered. The officer shall assess and consider:
(a) the existing provider's record of providing services and the applicant's record and ability to provide similar or improved services;
(b) locally established emergency medical services goals, including those established in Subsection (7);
(c) comment by local governments on the applicant's business and operations plans;
(d) comment by interested parties that are providers on the impact of the application on the parties' ability to provide emergency medical services;
(e) comment by interested parties that are local governments on the impact of the application on the citizens it represents; and
(f) public comment on any aspect of the application or proposed license.

(6) Other related criteria:
(a) the officer considers necessary; or
(b) established by department rule.

(7) Local governments shall establish cost, quality, and access goals for the ground ambulance and paramedic services that serve their areas.

(8) In a formal adjudicative proceeding, the applicant bears the burden of establishing that public convenience and necessity require the approval of the application for all or part of the exclusive geographic service area requested.

Amended by Chapter 326, 2017 General Session

26-8a-409 Ground ambulance and paramedic licenses -- Hearing and presiding officers.

(1) The department shall set training standards for hearing officers and presiding officers.

(2) At a minimum, a presiding officer shall:
(a) be familiar with the theory and application of public convenience and necessity; and
(b) have a working knowledge of the emergency medical service system in the state.

(3) In addition to the requirements in Subsection (2), a hearing officer shall also be licensed to practice law in the state.

(4) The department shall provide training for hearing officer and presiding officer candidates in the theory and application of public convenience and necessity and on the emergency medical system in the state.

(5) The department shall maintain a roster of no less than five individuals who meet the minimum qualifications for both presiding and hearing officers and the standards set by the department.
(6) The parties may mutually select an officer from the roster if the officer is available.
(7) If the parties cannot agree upon an officer under Subsection (4), the department shall randomly select an officer from the roster or from a smaller group of the roster agreed upon by the applicant and the objecting interested parties.

Amended by Chapter 326, 2017 General Session

26-8a-410 Local approvals.
(1) Licensed ambulance providers and paramedic providers shall meet all local zoning and business licensing standards generally applicable to businesses operating within the jurisdiction.
(2) Publicly subsidized providers shall demonstrate approval of the taxing authority that will provide the subsidy.
(3) A publicly operated service shall demonstrate that the governing body has approved the provision of services to the entire exclusive geographic service area that is the subject of the license, including those areas that may lie outside the territorial or jurisdictional boundaries of the governing body.

Amended by Chapter 297, 2011 General Session

26-8a-411 Limitation on repetitive applications.
A person who has previously applied for a license under Sections 26-8a-406 through 26-8a-409 may not apply for a license for the same service that covers any exclusive geographic service area that was the subject of the prior application unless:
(1) one year has passed from the date of the issuance of a final decision under Section 26-8a-407; or
(2) all interested parties and the department agree that a new application is in the public interest.

Amended by Chapter 213, 2003 General Session

26-8a-412 License for air ambulance providers.
(1) An applicant for an air ambulance provider shall apply to the department for a license only by:
  (a) submitting a complete application;
  (b) providing information in the format required by the department; and
  (c) paying the required fees.
(2) The department may make rules establishing minimum qualifications and requirements for:
  (a) personnel;
  (b) capital reserves;
  (c) equipment;
  (d) business plan;
  (e) operational procedures;
  (f) resource hospital and medical direction agreements;
  (g) management and control qualifications and requirements; and
  (h) other matters that may be relevant to an applicant's ability to provide air ambulance services.

(3) Upon receiving a completed application and the required fees, the department shall review the application and determine whether the application meets the minimum requirements for licensure.
(4) The department may deny an application for an air ambulance if:
(a) the department finds that the application contains any materially false or misleading information or is incomplete;
(b) the application demonstrates that the applicant fails to meet the minimum requirements for licensure; or
(c) the department finds after inspection that the applicant does not meet the minimum requirements for licensure.
(5) If the department denies an application under this section, it shall notify the applicant in writing setting forth the grounds for the denial.

Enacted by Chapter 141, 1999 General Session

26-8a-413 License renewals.
(1) A licensed provider desiring to renew its license shall meet the renewal requirements established by department rule.
(2) The department shall issue a renewal license for a ground ambulance provider or a paramedic provider upon the licensee's application for a renewal and without a public hearing if there has been:
(a) no change in controlling interest in the ownership of the licensee as defined in Section 26-8a-415;
(b) no serious, substantiated public complaints filed with the department against the licensee during the term of the previous license;
(c) no material or substantial change in the basis upon which the license was originally granted;
(d) no reasoned objection from the committee or the department; and
(e) if the applicant was licensed under the provisions of Sections 26-8a-406 through 26-8a-409, no conflicting license application.
(3)
(a)
(i) The provisions of this Subsection (3) apply to a provider licensed under the provisions of Sections 26-8a-405.1 and 26-8a-405.2.
(ii) A provider may renew its license if the provisions of Subsections (1), (2)(a) through (d), and this Subsection (3) are met.
(b)
(i) The department shall issue a renewal license to a provider upon the provider's application for renewal for one additional four-year term if the political subdivision certifies to the department that the provider has met all of the specifications of the original bid.
(ii) If the political subdivision does not certify to the department that the provider has met all of the specifications of the original bid, the department may not issue a renewal license and the political subdivision shall enter into a public bid process under Sections 26-8a-405.1 and 26-8a-405.2.
(c)
(i) The department shall issue an additional renewal license to a provider who has already been issued a one-time renewal license under the provisions of Subsection (3)(b)(i) if the department and the political subdivision do not receive, prior to the expiration of the provider's license, written notice from an approved applicant informing the political

subdivision of the approved applicant's desire to submit a bid for ambulance or paramedic service.

(ii) If the department and the political subdivision receive the notice in accordance with Subsection (3)(c)(i), the department may not issue a renewal license and the political subdivision shall enter into a public bid process under Sections 26-8a-405.1 and 26-8a-405.2.

(4) The department shall issue a renewal license for an air ambulance provider upon the licensee's application for renewal and completion of the renewal requirements established by department rule.

Amended by Chapter 297, 2011 General Session

26-8a-414 Annexations.

(1) A municipality shall comply with the provisions of this section if the municipality is licensed under this chapter and desires to provide service to an area that is:

(a) included in a petition for annexation under Title 10, Chapter 2, Part 4, Annexation; and

(b) currently serviced by another provider licensed under this chapter.

(2)

(a)

(i) At least 45 days prior to approving a petition for annexation, the municipality shall certify to the department that by the time of the approval of the annexation the municipality can meet or exceed the current level of service provided by the existing licensee for the annexed area by meeting the requirements of Subsections (2)(b)(ii)(A) through (D); and

(ii) no later than three business days after the municipality files a petition for annexation in accordance with Section 10-2-403, provide written notice of the petition for annexation to:

(A) the existing licensee providing service to the area included in the petition of annexation; and

(B) the department.

(b)

(i) After receiving a certification under Subsection (2)(a), but prior to the municipality approving a petition for annexation, the department may audit the municipality only to verify the requirements of Subsections (2)(b)(ii)(A) through (D).

(ii) If the department elects to conduct an audit, the department shall make a finding that the municipality can meet or exceed the current level of service provided by the existing licensee for the annexed area if the department finds that the municipality has or will have by the time of the approval of the annexation:

(A) adequate trained personnel to deliver basic and advanced life support services;

(B) adequate apparatus and equipment to deliver emergency medical services;

(C) adequate funding for personnel and equipment; and

(D) appropriate medical controls, such as a medical director and base hospital.

(iii) The department shall submit the results of the audit in writing to the municipal legislative body.

(3)

(a) If the department audit finds that the municipality meets the requirements of Subsection (2)(b)(ii), the department shall issue an amended license to the municipality and all other affected licensees to reflect the municipality's new boundaries after the department receives notice of the approval of the petition for annexation from the municipality in accordance with Section 10-2-425.

(b)
(i) Notwithstanding the provisions of Subsection 63G-4-102(2)(k), if the department audit finds that the municipality fails to meet the requirements of Subsection (2)(b)(ii), the municipality may request an adjudicative proceeding under the provisions of Title 63G, Chapter 4, Administrative Procedures Act. The municipality may approve the petition for annexation while an adjudicative proceeding requested under this Subsection (3)(b)(i) is pending.
(ii) The department shall conduct an adjudicative proceeding when requested under Subsection (3)(b)(i).
(iii) Notwithstanding the provisions of Sections 26-8a-404 through 26-8a-409, in any adjudicative proceeding held under the provisions of Subsection (3)(b)(i), the department bears the burden of establishing that the municipality cannot, by the time of the approval of the annexation, meet the requirements of Subsection (2)(b)(ii).
(c) If, at the time of the approval of the annexation, an adjudicative proceeding is pending under the provisions of Subsection (3)(b)(i), the department shall issue amended licenses if the municipality prevails in the adjudicative proceeding.

Amended by Chapter 382, 2008 General Session

26-8a-415 Changes in ownership.
(1) A licensed provider whose ownership or controlling ownership interest has changed shall submit information to the department, as required by department rule:
(a) to establish whether the new owner or new controlling party meets minimum requirements for licensure; and
(b) except as provided in Subsection (2), to commence an administrative proceeding to determine whether the new owner meets the requirement of public convenience and necessity under Section 26-8a-408.
(2) An administrative proceeding is not required under Subsection (1)(b) if:
(a) the change in ownership interest is among existing owners of a closely held corporation and the change does not result in a change in the management of the licensee or in the name of the licensee;
(b) the change in ownership in a closely held corporation results in the introduction of new owners, provided that:
(i) the new owners are limited to individuals who would be entitled to the equity in the closely held corporation by the laws of intestate succession had the transferor died intestate at the time of the transfer;
(ii) the majority owners on January 1, 1999, have been disclosed to the department by October 1, 1999, and the majority owners on January 1, 1999, retain a majority interest in the closely held corporation; and
(iii) the name of the licensed provider remains the same;
(c) the change in ownership is the result of one or more owners transferring their interests to a trust, limited liability company, partnership, or closely held corporation so long as the transferors retain control over the receiving entity;
(d) the change in ownership is the result of a distribution of an estate or a trust upon the death of the testator or the trustor and the recipients are limited to individuals who would be entitled to the interest by the laws of intestate succession had the transferor died intestate at the time of the transfer; or
(e) other similar changes that the department establishes, by rule, as having no significant impact on the cost, quality, or access to emergency medical services.

Enacted by Chapter 141, 1999 General Session

26-8a-416 Transition to eliminate inconsistent licenses.

(1) By May 30, 2000, the department shall review all licenses in effect on October 2, 1999, to identify overlap, as defined in department rule, in the service areas of two or more licensed providers.

(2) By June 30, 2000, the department shall notify all licensed providers affected by an overlap. By September 30, 2000, the department shall schedule, by order, a deadline to resolve each overlap, considering the effects on the licensed providers and the areas to be addressed.

(3) For each overlap, the department shall meet with the affected licensed providers and provide 120 days for a negotiated resolution, consistent with the criteria in Section 26-8a-408.

(4)

(a) If a resolution is reached under Subsection (2) that the department finds satisfies the criteria in Section 26-8a-408, the department shall amend the licenses to reflect the resolution consistent with Subsection (6).

(b) If a resolution is not reached under Subsection (2), the department or any of the licensed providers involved in the matter may request the commencement of a formal adjudicative proceeding to resolve the overlap.

(5) The department shall commence adjudicative proceedings for any overlap that is not resolved by July 1, 2003.

(6) Notwithstanding the exclusive geographic service requirement of Section 26-8a-402, the department may amend one or more licenses after a resolution is reached or an adjudicative proceeding has been held to allow:

(a) a single licensed provider to serve all or part of the overlap area;

(b) more than one licensed provider to serve the overlap area;

(c) licensed providers to provide different types of service in the overlap area; or

(d) licenses that recognize service arrangements that existed on September 30, 1999.

(7) Notwithstanding Subsection (6), any license for an overlap area terminates upon:

(a) relinquishment by the provider; or

(b) revocation by the department.

Enacted by Chapter 141, 1999 General Session

Part 5
Enforcement Provisions

26-8a-501 Discrimination prohibited.

(1) No person licensed or designated pursuant to this chapter may discriminate in the provision of emergency medical services on the basis of race, sex, color, creed, or prior inquiry as to ability to pay.

(2) This chapter does not authorize or require medical assistance or transportation over the objection of an individual on religious grounds.

Amended by Chapter 326, 2017 General Session

26-8a-502 Illegal activity.

(1) Except as provided in Section 26-8a-308 or 26-8b-201, a person may not:
  (a) practice or engage in the practice, represent that the person is practicing or engaging in the practice, or attempt to practice or engage in the practice of any activity that requires a license or designation under this chapter unless that person is licensed or designated under this chapter; or
  (b) offer an emergency medical service that requires a license or designation under this chapter unless the person is licensed or designated under this chapter.
(2) A person may not advertise or represent that the person holds a license or designation required under this chapter, unless that person holds the license or designation under this chapter.
(3) A person may not employ or permit any employee to perform any service for which a license is required by this chapter, unless the person performing the service possesses the required license under this chapter.
(4) A person may not wear, display, sell, reproduce, or otherwise use any Utah Emergency Medical Services insignia without authorization from the department.
(5) A person may not reproduce or otherwise use materials developed by the department for licensure testing or examination without authorization from the department.
(6) A person may not willfully summon an ambulance or emergency response vehicle or report that one is needed when the person knows that the ambulance or emergency response vehicle is not needed.
(7) A person who violates this section is subject to Section 26-23-6.

Amended by Chapter 326, 2017 General Session

26-8a-503 Discipline of emergency medical services personnel.

(1) The department may refuse to issue a license or renewal, or revoke, suspend, restrict, or place on probation an individual's license if:
  (a) the individual does not meet the qualifications for licensure under Section 26-8a-302;
  (b) the individual has engaged in conduct, as defined by committee rule, that:
    (i) is unprofessional;
    (ii) is adverse to the public health, safety, morals, or welfare; or
    (iii) would adversely affect public trust in the emergency medical service system;
  (c) the individual has violated Section 26-8a-502 or other provision of this chapter;
  (d) the individual has violated Section 58-1-509;
  (e) a court of competent jurisdiction has determined the individual to be mentally incompetent for any reason; or
  (f) the individual is unable to provide emergency medical services with reasonable skill and safety because of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material, or as a result of any other mental or physical condition, when the individual's condition demonstrates a clear and unjustifiable threat or potential threat to oneself, coworkers, or the public health, safety, or welfare that cannot be reasonably mitigated.
(2)
  (a) An action to revoke, suspend, restrict, or place a license on probation shall be done in:
    (i) consultation with the peer review board created in Section 26-8a-105; and
    (ii) accordance with Title 63G, Chapter 4, Administrative Procedures Act.
  (b) Notwithstanding Subsection (2)(a), the department may issue a cease and desist order under Section 26-8a-507 to immediately suspend an individual's license pending an administrative proceeding to be held within 30 days if there is evidence to show that the individual poses

a clear, immediate, and unjustifiable threat or potential threat to the public health, safety, or welfare.

(3) An individual whose license has been suspended, revoked, or restricted may apply for reinstatement of the license at reasonable intervals and upon compliance with any conditions imposed upon the license by statute, committee rule, or the terms of the suspension, revocation, or restriction.

(4) In addition to taking disciplinary action under Subsection (1), the department may impose sanctions in accordance with Section 26-23-6.

Amended by Chapter 346, 2019 General Session

26-8a-504 Discipline of designated and licensed providers.

(1) The department may refuse to issue a license or designation or a renewal, or revoke, suspend, restrict, or place on probation, an emergency medical service provider's license or designation if the provider has:

(a) failed to abide by terms of the license or designation;

(b) violated statute or rule;

(c) failed to provide services at the level or in the exclusive geographic service area required by the license or designation;

(d) failed to submit a renewal application in a timely fashion as required by department rule;

(e) failed to follow operational standards established by the committee; or

(f) committed an act in the performance of a professional duty that endangered the public or constituted gross negligence.

(2)

(a) An action to revoke, suspend, restrict, or place a license or designation on probation shall be done in accordance with Title 63G, Chapter 4, Administrative Procedures Act.

(b) Notwithstanding Subsection (2)(a), the department may issue a cease and desist order under Section 26-8a-507 to immediately suspend a license or designation pending an administrative proceeding to be held within 30 days if there is evidence to show that the provider or facility poses a clear, immediate, and unjustifiable threat or potential threat to the public health, safety, or welfare.

(3) In addition to taking disciplinary action under Subsection (1), the department may impose sanctions in accordance with Section 26-23-6.

Amended by Chapter 382, 2008 General Session

26-8a-505 Service interruption or cessation -- Receivership -- Default coverage -- Notice.

(1) Acting in the public interest, the department may petition the district court where an ambulance or paramedic provider operates or the district court with jurisdiction in Salt Lake County to appoint the department or an independent receiver to continue the operations of a provider upon any one of the following conditions:

(a) the provider ceases or intends to cease operations;

(b) the provider becomes insolvent;

(c) the department has initiated proceedings to revoke the provider's license and has determined that the lives, health, safety, or welfare of the population served within the provider's exclusive geographic service area are endangered because of the provider's action or inaction pending a full hearing on the license revocation; or

(d) the department has revoked the provider's license and has been unable to adequately arrange for another provider to take over the provider's exclusive geographic service area.
(2) If a licensed or designated provider ceases operations or is otherwise unable to provide services, the department may arrange for another licensed provider to provide services on a temporary basis until a license is issued.
(3) A licensed provider shall give the department 30 days notice of its intent to cease operations.

Enacted by Chapter 141, 1999 General Session

26-8a-506 Investigations for enforcement of chapter.
(1) The department may, for the purpose of ascertaining compliance with the provisions of this chapter, enter and inspect on a routine basis the business premises and equipment of a person:
(a) with a designation, permit, or license; or
(b) who holds himself out to the general public as providing a service for which a designation, permit, or license is required under Section 26-8a-301.
(2) Before conducting an inspection under Subsection (1), the department shall, after identifying the person in charge:
(a) give proper identification;
(b) describe the nature and purpose of the inspection; and
(c) if necessary, explain the authority of the department to conduct the inspection.
(3) In conducting an inspection under Subsection (1), the department may, after meeting the requirements of Subsection (2):
(a) inspect records, equipment, and vehicles; and
(b) interview personnel.
(4) An inspection conducted under Subsection (1) shall be during regular operational hours.

Amended by Chapter 326, 2017 General Session

26-8a-507 Cease and desist orders.
The department may issue a cease and desist order to any person who:
(1) may be disciplined under Section 26-8a-503 or 26-8a-504; or
(2) otherwise violates this chapter or any rules adopted under this chapter.

Enacted by Chapter 141, 1999 General Session

Part 6
Miscellaneous

26-8a-601 Persons and activities exempt from civil liability.
(1)
(a) Except as provided in Subsection (1)(b), a licensed physician, physician's assistant, or licensed registered nurse who, gratuitously and in good faith, gives oral or written instructions to any of the following is not liable for any civil damages as a result of issuing the instructions:
(i) an individual licensed under Section 26-8a-302;

(ii) a person who uses a fully automated external defibrillator, as defined in Section 26-8b-102; or

(iii) a person who administers CPR, as defined in Section 26-8b-102.

(b) The liability protection described in Subsection (1)(a) does not apply if the instructions given were the result of gross negligence or willful misconduct.

(2) An individual licensed under Section 26-8a-302, during either training or after licensure, a licensed physician, a physician assistant, or a registered nurse who, gratuitously and in good faith, provides emergency medical instructions or renders emergency medical care authorized by this chapter is not liable for any civil damages as a result of any act or omission in providing the emergency medical instructions or medical care, unless the act or omission is the result of gross negligence or willful misconduct.

(3) An individual licensed under Section 26-8a-302 is not subject to civil liability for failure to obtain consent in rendering emergency medical services authorized by this chapter to any individual who is unable to give his consent, regardless of the individual's age, where there is no other person present legally authorized to consent to emergency medical care, provided that the licensed individual acted in good faith.

(4) A principal, agent, contractor, employee, or representative of an agency, organization, institution, corporation, or entity of state or local government that sponsors, authorizes, supports, finances, or supervises any functions of an individual licensed under Section 26-8a-302 is not liable for any civil damages for any act or omission in connection with such sponsorship, authorization, support, finance, or supervision of the licensed individual where the act or omission occurs in connection with the licensed individual's training or occurs outside a hospital where the life of a patient is in immediate danger, unless the act or omission is inconsistent with the training of the licensed individual, and unless the act or omission is the result of gross negligence or willful misconduct.

(5) A physician or physician assistant who gratuitously and in good faith arranges for, requests, recommends, or initiates the transfer of a patient from a hospital to a critical care unit in another hospital is not liable for any civil damages as a result of such transfer where:

(a) sound medical judgment indicates that the patient's medical condition is beyond the care capability of the transferring hospital or the medical community in which that hospital is located; and

(b) the physician or physician assistant has secured an agreement from the receiving facility to accept and render necessary treatment to the patient.

(6) A person who is a registered member of the National Ski Patrol System (NSPS) or a member of a ski patrol who has completed a course in winter emergency care offered by the NSPS combined with CPR for medical technicians offered by the American Red Cross or American Heart Association, or an equivalent course of instruction, and who in good faith renders emergency care in the course of ski patrol duties is not liable for civil damages as a result of any act or omission in rendering the emergency care, unless the act or omission is the result of gross negligence or willful misconduct.

(7) An emergency medical service provider who, in good faith, transports an individual against his will but at the direction of a law enforcement officer pursuant to Section 62A-15-629 is not liable for civil damages for transporting the individual.

Amended by Chapter 349, 2019 General Session

26-8a-602 Notification of air ambulance policies and charges.

(1) For any patient who is in need of air medical transport provider services, an emergency medical service provider shall:
(a) provide the patient or the patient's representative with the information described in Subsection 26-8a-107(7)(a) before contacting an air medical transport provider; and
(b) if multiple air medical transport providers are capable of providing the patient with services, provide the patient or the patient's representative an opportunity to choose the air medical transport provider.
(2) Subsection (1) does not apply if the patient:
(a) is unconscious and the patient's representative is not physically present with the patient; or
(b) is unable, due to a medical condition, to make an informed decision about the choice of an air medical transport provider, and the patient's representative is not physically present with the patient.

Enacted by Chapter 262, 2019 General Session

Chapter 8b
Utah Sudden Cardiac Arrest Survival Act

Part 1
General Provisions

26-8b-101 Title.
This chapter is known as the "Utah Sudden Cardiac Arrest Survival Act."

Enacted by Chapter 22, 2009 General Session

26-8b-102 Definitions.
As used in this chapter:
(1) "Account" means the Automatic External Defibrillator Restricted Account, created in Section 26-8b-602.
(2) "Automatic external defibrillator" or "AED" means an automated or automatic computerized medical device that:
(a) has received pre-market notification approval from the United States Food and Drug Administration, pursuant to 21 U.S.C. Sec. 360(k);
(b) is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia;
(c) is capable of determining, without intervention by an operator, whether defibrillation should be performed; and
(d) upon determining that defibrillation should be performed, automatically charges, enabling delivery of, or automatically delivers, an electrical impulse through the chest wall and to a person's heart.
(3) "Bureau" means the Bureau of Emergency Medical Services, within the department.
(4) "Cardiopulmonary resuscitation" or "CPR" means artificial ventilation or external chest compression applied to a person who is unresponsive and not breathing.

(5) "Emergency medical dispatch center" means a public safety answering point, as defined in Section 63H-7a-103, that is designated as an emergency medical dispatch center by the bureau.
(6) "Sudden cardiac arrest" means a life-threatening condition that results when a person's heart stops or fails to produce a pulse.

Amended by Chapter 411, 2015 General Session

Part 2
Cardiopulmonary Resuscitation and Automatic External Defibrillators

26-8b-201 Authority to administer CPR or use an AED.

(1) A person may administer CPR on another person without a license, certificate, or other governmental authorization if the person reasonably believes that the other person is in sudden cardiac arrest.
(2) A person may use an AED on another person without a license, certificate, or other governmental authorization if the person reasonably believes that the other person is in sudden cardiac arrest.

Enacted by Chapter 22, 2009 General Session

26-8b-202 Immunity.

(1) Except as provided in Subsection (3), the following persons are not subject to civil liability for any act or omission relating to preparing to care for, responding to care for, or providing care to, another person who reasonably appears to be in sudden cardiac arrest:
  (a) a person authorized, under Section 26-8b-201, to administer CPR, who:
    (i) gratuitously and in good faith attempts to administer or administers CPR to another person; or
    (ii) fails to administer CPR to another person;
  (b) a person authorized, under Section 26-8b-201, to use an AED who:
    (i) gratuitously and in good faith attempts to use or uses an AED; or
    (ii) fails to use an AED;
  (c) a person that teaches or provides a training course in administering CPR or using an AED;
  (d) a person that acquires an AED;
  (e) a person that owns, manages, or is otherwise responsible for the premises or conveyance where an AED is located;
  (f) a person who retrieves an AED in response to a perceived or potential sudden cardiac arrest;
  (g) a person that authorizes, directs, or supervises the installation or provision of an AED;
  (h) a person involved with, or responsible for, the design, management, or operation of a CPR or AED program;
  (i) a person involved with, or responsible for, reporting, receiving, recording, updating, giving, or distributing information relating to the ownership or location of an AED under Part 3, Automatic External Defibrillator Databases; or
  (j) a physician who gratuitously and in good faith:
    (i) provides medical oversight for a public AED program; or
    (ii) issues a prescription for a person to acquire or use an AED.

(2) This section does not relieve a manufacturer, designer, developer, marketer, or commercial distributor of an AED, or an accessory for an AED, of any liability.
(3) The liability protection described in Subsection (1) does not apply to an act or omission that constitutes gross negligence or willful misconduct.

Enacted by Chapter 22, 2009 General Session

Part 3
Automatic External Defibrillator Databases

26-8b-301 Reporting location of automatic external defibrillators.
(1) In accordance with Subsection (2) and except as provided in Subsection (3):
  (a) a person who owns or leases an AED shall report the person's name, address, and telephone number, and the exact location of the AED, in writing or by a web-based AED registration form, if available, to the emergency medical dispatch center that provides emergency dispatch services for the location where the AED is installed, if the person:
    (i) installs the AED;
    (ii) causes the AED to be installed; or
    (iii) allows the AED to be installed; and
  (b) a person who owns or leases an AED that is removed from a location where it is installed shall report the person's name, address, and telephone number, and the exact location from which the AED is removed, in writing or by a web-based AED registration form, if available, to the emergency medical dispatch center that provides emergency dispatch services for the location from which the AED is removed, if the person:
    (i) removes the AED;
    (ii) causes the AED to be removed; or
    (iii) allows the AED to be removed.
(2) A report required under Subsection (1) shall be made within 14 days after the day on which the AED is installed or removed.
(3) Subsection (1) does not apply to an AED:
  (a) at a private residence; or
  (b) in a vehicle or other mobile or temporary location.
(4) A person who owns or leases an AED that is installed in, or removed from, a private residence may voluntarily report the location of, or removal of, the AED to the emergency medical dispatch center that provides emergency dispatch services for the location where the private residence is located.
(5) The department may not impose a penalty on a person for failing to comply with the requirements of this section.

Amended by Chapter 98, 2013 General Session

26-8b-302 Distributors to notify of reporting requirements.
A person in the business of selling or leasing an AED shall, at the time the person provides, sells, or leases an AED to another person, notify the other person, in writing, of the reporting requirements described in Section 26-8b-301.

Enacted by Chapter 22, 2009 General Session

26-8b-303 Duties of emergency medical dispatch centers.

An emergency medical dispatch center shall:

(1) implement a system to receive and manage the information reported to the emergency medical dispatch center under Section 26-8b-301;

(2) record in the system described in Subsection (1), all information received under Section 26-8b-301 within 14 days after the day on which the information is received;

(3) inform a person who calls to report a potential incident of sudden cardiac arrest of the location of an AED located at the address of the potential sudden cardiac arrest;

(4) provide verbal instructions to a person described in Subsection (3) to:

(a) help a person determine if a patient is in cardiac arrest; and

(b) if needed:

(i) provide direction to start CPR;

(ii) offer instructions on how to perform CPR; or

(iii) offer instructions on how to use an AED, if one is available; and

(5) provide the information contained in the system described in Subsection (1), upon request, to the bureau.

Amended by Chapter 98, 2013 General Session

Part 4
Education and Training

26-8b-401 Education and training.

(1) The bureau shall work in cooperation with federal, state, and local agencies and schools, to encourage individuals to complete courses on the administration of CPR and the use of an AED.

(2) A person who owns or leases an AED shall encourage each person who is likely to use the AED to complete courses on the administration of CPR and the use of an AED.

Enacted by Chapter 22, 2009 General Session

26-8b-402 AEDs for demonstration purposes.

(1) Any AED used solely for demonstration or training purposes, which is not operational for emergency use is, except for the provisions of this section, exempt from the provisions of this chapter.

(2) The owner of an AED described in Subsection (1) shall clearly mark on the exterior of the AED that the AED is for demonstration or training use only.

Enacted by Chapter 98, 2013 General Session

Part 5
Automatic External Defibrillator Tampering -- Penalties

26-8b-501 Tampering with an AED prohibited -- Penalties.

A person is guilty of a class C misdemeanor if the person removes, tampers with, or otherwise disturbs an AED, AED cabinet or enclosure, or AED sign, unless:

(1) the person is authorized by the AED owner for the purpose of:
  (a) inspecting the AED or AED cabinet or enclosure; or
  (b) performing maintenance or repairs on the AED, the AED cabinet or enclosure, a wall or structure that the AED cabinet or enclosure is directly attached to, or an AED sign;
(2) the person is responding to, or providing care to, a potential sudden cardiac arrest patient; or
(3) the person acts in good faith with the intent to support, and not to violate, the recognized purposes of the AED.

Enacted by Chapter 98, 2013 General Session

Part 6
Automatic External Defibrillator Restricted Account

26-8b-601 Title.

This part is known as the "Automatic External Defibrillator Restricted Account."

Enacted by Chapter 99, 2013 General Session

26-8b-602 Automatic External Defibrillator Restricted Account.

(1)
  (a) There is created a restricted account within the General Fund known as the Automatic External Defibrillator Restricted Account to provide AEDs to entities under Subsection (4).
  (b) The director of the bureau shall administer the account in accordance with rules made by the bureau in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(2) The restricted account shall consist of money appropriated to the account by the Legislature.
(3) The director of the bureau shall distribute funds deposited in the account to eligible entities, under Subsection (4), for the purpose of purchasing:
  (a) an AED;
  (b) an AED carrying case;
  (c) a wall-mounted AED cabinet; or
  (d) an AED sign.
(4) Upon appropriation, the director of the bureau shall distribute funds deposited in the account, for the purpose of purchasing items under Subsection (3), to:
  (a) a municipal department of safety that routinely responds to incidents, or potential incidents, of sudden cardiac arrest;
  (b) a municipal or county law enforcement agency that routinely responds to incidents, or potential incidents, of sudden cardiac arrest;
  (c) a state law enforcement agency that routinely responds to incidents, or potential incidents, of sudden cardiac arrest;
  (d) a school that offers instruction to grades kindergarten through 6;
  (e) a school that offers instruction to grades 7 through 12; or
  (f) a state institution of higher education.

(5) The director of the bureau shall distribute funds under this section to a municipality only if the municipality provides a match in funding for the total cost of items under Subsection (3):
(a) of 50% for the municipality, if the municipality is a city of first, second, or third class under Section 10-2-301; or
(b) of 75% for the municipality, other than a municipality described in Subsection (5)(a).
(6) The director of the bureau shall distribute funds under this section to a county only if the county provides a match in funding for the total cost of items under Subsection (3):
(a) of 50% for the county, if the county is a county of first, second, or third class under Section 17-50-501; or
(b) of 75% for the county, other than a county described in Subsection (6)(a).
(7) In accordance with rules made by the bureau, an entity described in Subsection (4) may apply to the director of the bureau to receive a distribution of funds from the account by filing an application with the bureau on or before October 1 of each year.

Amended by Chapter 109, 2014 General Session

Chapter 8c
Ems Personnel Licensure Interstate Compact

26-8c-101 Title.

This chapter is known as the "EMS Personnel Licensure Interstate Compact."

Enacted by Chapter 97, 2016 General Session

26-8c-102 EMS Personnel Licensure Interstate Compact.

EMS PERSONNEL LICENSURE INTERSTATE COMPACT

SECTION 1. PURPOSE

In order to protect the public through verification of competency and ensure accountability for patient care related activities all states license emergency medical services (EMS) personnel, such as emergency medical technicians (EMTs), advanced EMTs and paramedics. This Compact is intended to facilitate the day to day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority and authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state. This Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of EMS personnel and that such state regulation shared among the member states will best protect public health and safety. This Compact is designed to achieve the following purposes and objectives:

1. Increase public access to EMS personnel;

2. Enhance the states' ability to protect the public's health and safety, especially patient safety;

3. Encourage the cooperation of member states in the areas of EMS personnel licensure and regulation;

4. Support licensing of military members who are separating from an active duty tour and their spouses;

5. Facilitate the exchange of information between member states regarding EMS personnel licensure, adverse action and significant investigatory information;

6. Promote compliance with the laws governing EMS personnel practice in each member state; and

7. Invest all member states with the authority to hold EMS personnel accountable through the mutual recognition of member state licenses.

SECTION 2. DEFINITIONS

In this compact:

A. "Advanced Emergency Medical Technician (AEMT)" means: an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

B. "Adverse Action" means: any administrative, civil, equitable or criminal action permitted by a state's laws which may be imposed against licensed EMS personnel by a state EMS authority or state court, including, but not limited to, actions against an individual's license such as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual's practice, letters of reprimand or admonition, fines, criminal convictions and state court judgments enforcing adverse actions by the state EMS authority.

C. "Alternative program" means: a voluntary, non-disciplinary substance abuse recovery program approved by a state EMS authority.

D. "Certification" means: the successful verification of entry-level cognitive and psychomotor competency using a reliable, validated, and legally defensible examination.

E. "Commission" means: the national administrative body of which all states that have enacted the compact are members.

F. "Emergency Medical Technician (EMT)" means: an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

G. "Home State" means: a member state where an individual is licensed to practice emergency medical services.

H. "License" means: the authorization by a state for an individual to practice as an EMT, AEMT, paramedic, or a level in between EMT and paramedic.

I. "Medical Director" means: a physician licensed in a member state who is accountable for the care delivered by EMS personnel.

J. "Member State" means: a state that has enacted this compact.

K. "Privilege to Practice" means: an individual's authority to deliver emergency medical services in remote states as authorized under this compact.

L. "Paramedic" means: an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

M. "Remote State" means: a member state in which an individual is not licensed.

N. "Restricted" means: the outcome of an adverse action that limits a license or the privilege to practice.

O. "Rule" means: a written statement by the interstate Commission promulgated pursuant to Section 12 of this compact that is of general applicability; implements, interprets, or prescribes a policy or provision of the compact; or is an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a member state and includes the amendment, repeal, or suspension of an existing rule.

P. "Scope of Practice" means: defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it tends to represent the limits of services an individual may perform.

Q. "Significant Investigatory Information" means:

1. investigative information that a state EMS authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proved true, would result in the imposition of an adverse action on a license or privilege to practice; or

2. investigative information that indicates that the individual represents an immediate threat to public health and safety regardless of whether the individual has been notified and had an opportunity to respond.

R. "State" means: means any state, commonwealth, district, or territory of the United States.

S. "State EMS Authority" means: the board, office, or other agency with the legislative mandate to license EMS personnel.

SECTION 3. HOME STATE LICENSURE

A. Any member state in which an individual holds a current license shall be deemed a home state for purposes of this compact.

B. Any member state may require an individual to obtain and retain a license to be authorized to practice in the member state under circumstances not authorized by the privilege to practice under the terms of this compact.

C. A home state's license authorizes an individual to practice in a remote state under the privilege to practice only if the home state:

1. Currently requires the use of the National Registry of Emergency Medical Technicians (NREMT) examination as a condition of issuing initial licenses at the EMT and paramedic levels;

2. Has a mechanism in place for receiving and investigating complaints about individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding an individual;

4. No later than five years after activation of the Compact, requires a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation with the exception of federal employees who have suitability determination in accordance with 5 C.F.R. Sec. 731.202 and submit documentation of such as promulgated in the rules of the Commission; and

5. Complies with the rules of the Commission.

SECTION 4. COMPACT PRIVILEGE TO PRACTICE

A. Member states shall recognize the privilege to practice of an individual licensed in another member state that is in conformance with Section 3.

B. To exercise the privilege to practice under the terms and provisions of this compact, an individual must:

1. Be at least 18 years of age;

2. Possess a current unrestricted license in a member state as an EMT, AEMT, paramedic, or state recognized and licensed level with a scope of practice and authority between EMT and paramedic; and

3. Practice under the supervision of a medical director.

C. An individual providing patient care in a remote state under the privilege to practice shall function within the scope of practice authorized by the home state unless and until modified by an appropriate authority in the remote state as may be defined in the rules of the commission.

D. Except as provided in Section 4 subsection C, an individual practicing in a remote state will be subject to the remote state's authority and laws. A remote state may, in accordance with due process and that state's laws, restrict, suspend, or revoke an individual's privilege to practice in the remote state and may take any other necessary actions to protect the health and safety of its citizens. If a remote state takes action it shall promptly notify the home state and the Commission.

E. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

F. If an individual's privilege to practice in any remote state is restricted, suspended, or revoked the individual shall not be eligible to practice in any remote state until the individual's privilege to practice is restored.

SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE

An individual may practice in a remote state under a privilege to practice only in the performance of the individual's EMS duties as assigned by an appropriate authority, as defined in the rules of the Commission, and under the following circumstances:

1. The individual originates a patient transport in a home state and transports the patient to a remote state;

2. The individual originates in the home state and enters a remote state to pick up a patient and provide care and transport of the patient to the home state;

3. The individual enters a remote state to provide patient care and/or transport within that remote state;

4. The individual enters a remote state to pick up a patient and provide care and transport to a third member state;

5. Other conditions as determined by rules promulgated by the commission.

SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT ASSISTANCE COMPACT

Upon a member state's governor's declaration of a state of emergency or disaster that activates the Emergency Management Assistance Compact (EMAC), all relevant terms and provisions of EMAC shall apply and to the extent any terms or provisions of this Compact conflicts with EMAC, the terms of EMAC shall prevail with respect to any individual practicing in the remote state in response to such declaration.

SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING FROM ACTIVE DUTY MILITARY, AND THEIR SPOUSES

A. Member states shall consider a veteran, active military service member, and member of the National Guard and Reserves separating from an active duty tour, and a spouse thereof, who holds a current valid and unrestricted NREMT certification at or above the level of the state license being sought as satisfying the minimum training and examination requirements for such licensure.

B. Member states shall expedite the processing of licensure applications submitted by veterans, active military service members, and members of the National Guard and Reserves separating from an active duty tour, and their spouses.

C. All individuals functioning with a privilege to practice under this Section remain subject to the Adverse Actions provisions of Section VIII.

SECTION 8. ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against an individual's license issued by the home state.

B. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

1. All home state adverse action orders shall include a statement that the individual's compact privileges are inactive. The order may allow the individual to practice in remote states with prior written authorization from both the home state and remote state's EMS authority.

2. An individual currently subject to adverse action in the home state shall not practice in any remote state without prior written authorization from both the home state and remote state's EMS authority.

C. A member state shall report adverse actions and any occurrences that the individual's compact privileges are restricted, suspended, or revoked to the Commission in accordance with the rules of the Commission.

D. A remote state may take adverse action on an individual's privilege to practice within that state.

E. Any member state may take adverse action against an individual's privilege to practice in that state based on the factual findings of another member state, so long as each state follows its own procedures for imposing such adverse action.

F. A home state's EMS authority shall investigate and take appropriate action with respect to reported conduct in a remote state as it would if such conduct had occurred within the home state. In such cases, the home state's law shall control in determining the appropriate adverse action.

G. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the member state's laws. Member states must require individuals who enter any alternative programs to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

SECTION 9. ADDITIONAL POWERS INVESTED
IN A MEMBER STATE'S EMS AUTHORITY

A member state's EMS authority, in addition to any other powers granted under state law, is authorized under this compact to:

1. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a member state's EMS authority for the attendance and testimony of witnesses, and/or the production of evidence from another member state, shall be enforced in the remote state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state EMS authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

2. Issue cease and desist orders to restrict, suspend, or revoke an individual's privilege to practice in the state.

SECTION 10. ESTABLISHMENT OF THE INTERSTATE
COMMISSION FOR EMS PERSONNEL PRACTICE

A. The Compact states hereby create and establish a joint public agency known as the Interstate Commission for EMS Personnel Practice.

1. The Commission is a body politic and an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. Each member state shall have and be limited to one (1) delegate. The responsible official of the state EMS authority or his designee shall be the delegate to this Compact for each member state. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office, or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the Governor of the state will determine which entity will be responsible for assigning the delegate.

2. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section XII.

5. The Commission may convene in a closed, non-public meeting if the Commission must discuss:

a. Non-compliance of a member state with its obligations under the Compact;

b. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the delegates, prescribe bylaws and/or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. for the establishment and meetings of other committees; and

b. governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the membership votes to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed;

4. Establishing the titles, duties and authority, and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any member state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

8. The Commission shall publish its bylaws and file a copy thereof, and a copy of any amendment thereto, with the appropriate agency or officer in each of the member states, if any.

9. The Commission shall maintain its financial records in accordance with the bylaws.

10. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

D. The Commission shall have the following powers:

1. The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state EMS authority or other regulatory body responsible for EMS personnel licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this compact and the bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of EMS personnel licensure and practice.

E. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

F. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 11. COORDINATED DATABASE

A. The Commission shall provide for the development and maintenance of a coordinated database and reporting system containing licensure, adverse action, and significant investigatory information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the coordinated database on all individuals to whom this compact is applicable as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Significant investigatory information;
4. Adverse actions against an individual's license;
5. An indicator that an individual's privilege to practice is restricted, suspended or revoked;
6. Non-confidential information related to alternative program participation;
7. Any denial of application for licensure, and the reason(s) for such denial; and
8. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

C. The coordinated database administrator shall promptly notify all member states of any adverse action taken against, or significant investigative information on, any individual in a member state.

D. Member states contributing information to the coordinated database may designate information that may not be shared with the public without the express permission of the contributing state.

E. Any information submitted to the coordinated database that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the coordinated database.

SECTION 12. RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission; and
2. On the website of each member state EMS authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in

format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 13. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the compact that arise among member states and between member and non-member states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 14. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The compact shall come into effect on the date on which the compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the compact.

B. Any state that joins the compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the compact becomes law in that state.

C. Any member state may withdraw from this compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's EMS authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this compact shall be construed to invalidate or prevent any EMS personnel licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 15. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this compact shall be held contrary to the constitution of any state member thereto, the compact shall remain in full force and effect as to the remaining member states. Nothing in this compact supersedes state law or rules related to licensure of EMS agencies.

Enacted by Chapter 97, 2016 General Session

Chapter 8d
Utah Statewide Stroke and Cardiac Registry Act

26-8d-101 Title.

This chapter is known as the "Utah Statewide Stroke and Cardiac Registry Act."

Enacted by Chapter 104, 2018 General Session

26-8d-102 Statewide stroke registry.

(1) The department shall establish and supervise a statewide stroke registry to:
  (a) analyze information on the incidence, severity, causes, outcomes, and rehabilitation of stroke;
  (b) promote optimal care for stroke patients;
  (c) alleviate unnecessary death and disability from stroke;
  (d) encourage the efficient and effective continuum of patient care, including prevention, prehospital care, hospital care, and rehabilitative care; and
  (e) minimize the overall cost of stroke.
(2) The department shall utilize the registry established under Subsection (1) to assess:
  (a) the effectiveness of the data collected by the registry; and
  (b) the impact of the statewide stroke registry on the provision of stroke care.
(3)
  (a) The department shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish:
    (i) the data elements that general acute hospitals shall report to the registry; and
    (ii) the time frame and format for reporting.
  (b) The data elements described in Subsection (3)(a)(i) shall include consensus metrics consistent with data elements used in nationally recognized data set platforms for stroke care.
  (c) The department shall permit a general acute hospital to submit data required under this section through an electronic exchange of clinical health information that meets the standards established by the department under Section 26-1-37.
(4) A general acute hospital shall submit stroke data in accordance with rules established under Subsection (3).
(5) Data collected under this section shall be subject to Chapter 3, Health Statistics.
(6) No person may be held civilly liable for providing data to the department in accordance with this section.

Enacted by Chapter 104, 2018 General Session

26-8d-103 Statewide cardiac registry.

(1) The department shall establish and supervise a statewide cardiac registry to:
  (a) analyze information on the incidence, severity, causes, outcomes, and rehabilitation of cardiac diseases;
  (b) promote optimal care for cardiac patients;
  (c) alleviate unnecessary death and disability from cardiac diseases;
  (d) encourage the efficient and effective continuum of patient care, including prevention, prehospital care, hospital care, and rehabilitative care; and

(e) minimize the overall cost of cardiac care.
(2) The department shall utilize the registry established under Subsection (1) to assess:
(a) the effectiveness of the data collected by the registry; and
(b) the impact of the statewide cardiac registry on the provision of cardiac care.
(3)
(a) The department shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to establish:
(i) the data elements that general acute hospitals shall report to the registry; and
(ii) the time frame and format for reporting.
(b) The data elements described in Subsection (3)(a)(i) shall include consensus metrics consistent with data elements used in nationally recognized data set platforms for cardiac care.
(c) The department shall permit a general acute hospital to submit data required under this section through an electronic exchange of clinical health information that meets the standards established by the department under Section 26-1-37.
(4) A general acute hospital shall submit cardiac data in accordance with rules established under Subsection (3).
(5) Data collected under this section shall be subject to Chapter 3, Health Statistics.
(6) No person may be held civilly liable for providing data to the department in accordance with this section.

Enacted by Chapter 104, 2018 General Session

26-8d-104 Stroke registry advisory committee.
(1) There is created within the department a stroke registry advisory committee.
(2) The stroke registry advisory committee created in Subsection (1) shall:
(a) be composed of individuals knowledgeable in adult and pediatric stroke care, including physicians, physician assistants, nurses, hospital administrators, emergency medical services personnel, government officials, consumers, and persons affiliated with professional health care associations;
(b) advise the department regarding the development and implementation of the stroke registry;
(c) assist the department in evaluating the quality and outcomes of the stroke registry; and
(d) review and comment on proposals and rules governing the statewide stroke registry.

Amended by Chapter 349, 2019 General Session

26-8d-105 Cardiac registry advisory committee.
(1) There is created within the department a cardiac registry advisory committee.
(2) The cardiac registry advisory committee created in Subsection (1) shall:
(a) be composed of individuals knowledgeable in adult and pediatric cardiac care, including physicians, physician assistants, nurses, hospital administrators, emergency medical services personnel, government officials, consumers, and persons affiliated with professional health care associations;
(b) advise the department regarding the development and implementation of the cardiac registry;
(c) assist the department in evaluating the quality and outcomes of the cardiac registry; and
(d) review and comment on proposals and rules governing the statewide cardiac registry.

Amended by Chapter 349, 2019 General Session

Chapter 9
Rural Health Services

Part 1
Department Responsibilities

26-9-1 Assistance to rural communities by department.

The department shall assist rural communities in dealing with primary health care needs relating to recruiting health professionals, planning, and technical assistance. The department shall assist the communities, at their request, at any stage of development of new or expanded primary health care services and shall work with them to improve primary health care by providing information to increase the effectiveness of their systems, to decrease duplication and fragmentation of services, and to maximize community use of private gifts, and local, state, and federal grants and contracts.

Enacted by Chapter 126, 1981 General Session

26-9-2 Responsibility of department for coordinating rural health programs.

The department shall be the lead agency responsible for coordinating rural health programs and shall insure that resources available for rural health are efficiently and effectively used.

Enacted by Chapter 126, 1981 General Session

26-9-3 Rural health development initiatives.

(1)
(a) The University of Utah Health Science Center shall use any appropriations it receives for developing area health education centers to establish and maintain an area health education center program in accordance with this section.
(b) Implementation and execution of the area health education center program is contingent upon appropriations from the Legislature.

(2)
(a) The area health education center program shall consist of a central program office at the University of Utah Health Science Center. The program office shall establish and operate a statewide, decentralized, regional program with emphasis on addressing rural health professions workforce education and training needs.
(b) The area health education center program shall have five regional centers serving the following geographic areas:
(i) the northern center serving Box Elder, Cache, Rich, Weber, and Morgan counties;
(ii) the crossroads center serving Salt Lake, Wasatch, Summit, Tooele, Utah, and Davis counties;
(iii) the central center serving Juab, Millard, Piute, Sanpete, Sevier, and Wayne counties;
(iv) the eastern center serving Carbon, Daggett, Duchesne, Emery, Grand, San Juan, and Uintah counties; and
(v) the southwest center serving Beaver, Garfield, Iron, Kane, and Washington counties.

(3) The area health education center program shall attempt to acquire funding from state, local, federal, and private sources.

(4) Each area health education center shall provide community-based health professions education programming for the geographic area described in Subsection (2)(b) of this section.

Amended by Chapter 95, 2001 General Session

26-9-4 Rural Health Care Facilities Account -- Source of revenues -- Interest -- Distribution of revenues -- Expenditure of revenues -- Unexpended revenues lapse into the General Fund.

(1) As used in this section:
(a) "Emergency medical services" is as defined in Section 26-8a-102.
(b) "Federally qualified health center" is as defined in 42 U.S.C. Sec. 1395x.
(c) "Fiscal year" means a one-year period beginning on July 1 of each year.
(d) "Freestanding urgent care center" is as defined in Section 59-12-801.
(e) "Nursing care facility" is as defined in Section 26-21-2.
(f) "Rural city hospital" is as defined in Section 59-12-801.
(g) "Rural county health care facility" is as defined in Section 59-12-801.
(h) "Rural county hospital" is as defined in Section 59-12-801.
(i) "Rural county nursing care facility" is as defined in Section 59-12-801.
(j) "Rural emergency medical services" is as defined in Section 59-12-801.
(k) "Rural health clinic" is as defined in 42 U.S.C. Sec. 1395x.
(2) There is created a restricted account within the General Fund known as the "Rural Health Care Facilities Account."
(3)
(a) The restricted account shall be funded by amounts appropriated by the Legislature.
(b) Any interest earned on the restricted account shall be deposited into the General Fund.
(4) Subject to Subsections (5) and (6), the State Tax Commission shall for a fiscal year distribute money deposited into the restricted account to each:
(a) county legislative body of a county that, on January 1, 2007, imposes a tax in accordance with Section 59-12-802 and has not repealed the tax; or
(b) city legislative body of a city that, on January 1, 2007, imposes a tax in accordance with Section 59-12-804 and has not repealed the tax.
(5)
(a) Subject to Subsection (6), for purposes of the distribution required by Subsection (4), the State Tax Commission shall:
(i) estimate for each county and city described in Subsection (4) the amount by which the revenues collected from the taxes imposed under Sections 59-12-802 and 59-12-804 for fiscal year 2005-06 would have been reduced had:
(A) the amendments made by Laws of Utah 2007, Chapter 288, Sections 25 and 26, to Sections 59-12-802 and 59-12-804 been in effect for fiscal year 2005-06; and
(B) each county and city described in Subsection (4) imposed the tax under Sections 59-12-802 and 59-12-804 for the entire fiscal year 2005-06;
(ii)
(A) for fiscal years ending before fiscal year 2018, calculate a percentage for each county and city described in Subsection (4) by dividing the amount estimated for each county and city in accordance with Subsection (5)(a)(i) by $555,000; and
(B) beginning in fiscal year 2018, calculate a percentage for each county and city described in Subsection (4) by dividing the amount estimated for each county and city in accordance with Subsection (5)(a)(i) by $218,809.33;

(iii) distribute to each county and city described in Subsection (4) an amount equal to the product of:
(A) the percentage calculated in accordance with Subsection (5)(a)(ii); and
(B) the amount appropriated by the Legislature to the restricted account for the fiscal year.
(b) The State Tax Commission shall make the estimations, calculations, and distributions required by Subsection (5)(a) on the basis of data collected by the State Tax Commission.
(6) If a county legislative body repeals a tax imposed under Section 59-12-802 or a city legislative body repeals a tax imposed under Section 59-12-804:
(a) the commission shall determine in accordance with Subsection (5) the distribution that, but for this Subsection (6), the county legislative body or city legislative body would receive; and
(b) after making the determination required by Subsection (6)(a), the commission shall:
(i) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is October 1:
(A)
(I) distribute to the county legislative body or city legislative body 25% of the distribution determined in accordance with Subsection (6)(a); and
(II) deposit 75% of the distribution determined in accordance with Subsection (6)(a) into the General Fund; and
(B) beginning with the first fiscal year after the effective date of the repeal and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund;
(ii) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is January 1:
(A)
(I) distribute to the county legislative body or city legislative body 50% of the distribution determined in accordance with Subsection (6)(a); and
(II) deposit 50% of the distribution determined in accordance with Subsection (6)(a) into the General Fund; and
(B) beginning with the first fiscal year after the effective date of the repeal and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund;
(iii) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is April 1:
(A)
(I) distribute to the county legislative body or city legislative body 75% of the distribution determined in accordance with Subsection (6)(a); and
(II) deposit 25% of the distribution determined in accordance with Subsection (6)(a) into the General Fund; and
(B) beginning with the first fiscal year after the effective date of the repeal and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund; or
(iv) if the effective date of the repeal of a tax imposed under Section 59-12-802 or 59-12-804 is July 1, beginning on that effective date and for each subsequent fiscal year, deposit the entire amount of the distribution determined in accordance with Subsection (6)(a) into the General Fund.
(7)
(a) Subject to Subsection (7)(b) and Section 59-12-802, a county legislative body shall distribute the money the county legislative body receives in accordance with Subsection (5) or (6):

(i) for a county of the third or fourth class, to fund rural county health care facilities in that county; and
(ii) for a county of the fifth or sixth class, to fund:
(A) rural emergency medical services in that county;
(B) federally qualified health centers in that county;
(C) freestanding urgent care centers in that county;
(D) rural county health care facilities in that county;
(E) rural health clinics in that county; or
(F) a combination of Subsections (7)(a)(ii)(A) through (E).
(b) A county legislative body shall distribute the money the county legislative body receives in accordance with Subsection (5) or (6) to a center, clinic, facility, or service described in Subsection (7)(a) as determined by the county legislative body.
(c) A center, clinic, facility, or service that receives a distribution in accordance with this Subsection (7) shall expend that distribution for the same purposes for which money collected from a tax under Section 59-12-802 may be expended.
(8)
(a) Subject to Subsection (8)(b), a city legislative body shall distribute the money the city legislative body receives in accordance with Subsection (5) or (6) to fund rural city hospitals in that city.
(b) A city legislative body shall distribute a percentage of the money the city legislative body receives in accordance with Subsection (5) or (6) to each rural city hospital described in Subsection (8)(a) equal to the same percentage that the city legislative body distributes to that rural city hospital in accordance with Section 59-12-805 for the calendar year ending on the December 31 immediately preceding the first day of the fiscal year for which the city legislative body receives the distribution in accordance with Subsection (5) or (6).
(c) A rural city hospital that receives a distribution in accordance with this Subsection (8) shall expend that distribution for the same purposes for which money collected from a tax under Section 59-12-804 may be expended.
(9) Any money remaining in the Rural Health Care Facilities Account at the end of a fiscal year after the State Tax Commission makes the distributions required by this section shall lapse into the General Fund.

Amended by Chapter 199, 2017 General Session

26-9-5 Rural County Health Care Special Service District Retirement Grant Program.
(1) As used in this section:
(a) "Participating employer" means an employer that was required to participate in the Utah State Retirement System under Section 49-12-201, 49-12-202, 49-13-201, or 49-13-202.
(b) "Retirement liability" means an obligation in excess of $750,000 owed to the Utah State Retirement Office by a rural county health care special service district as a participating employer.
(c) "Rural county health care special service district" means a special service district formed to provide health care in a third, fourth, fifth, or sixth class county as defined in Section 17-50-501.
(2) Because there is a compelling statewide public purpose in promoting health care in Utah's rural counties, and particularly in ensuring the continued existence and financial viability of hospital services provided by rural county health care special service districts, there is created a grant

program to assist rural county health care special service districts in meeting a retirement liability.

(3)

(a) Subject to legislative appropriation and this Subsection (3), the department shall make grants to rural county health care special service districts.

(b) To qualify for a grant, a rural county health care special service district shall:

(i) file a grant application with the department detailing:

(A) the name of the rural county health care special service district;

(B) the estimated total amount of the retirement liability;

(C) the grant amount that the rural county health care special service district is requesting; and

(D) the amount of matching funds to be provided by the rural county health care special service district to help fund the retirement liability as required by Subsection (3)(d); and

(ii) commit to provide matching funds as required by Subsection (3)(d).

(c) The department shall review each grant application and, subject to legislative appropriation, award grants to each rural health care special service district that qualifies for a grant under Subsection (3)(b).

(d) The department may not award a grant to a rural county health care special service district unless the rural county health care special service district commits to provide matching funds to the grant equal to at least 40% of the amount of the grant.

Enacted by Chapter 408, 2012 General Session

Chapter 9f
Utah Digital Health Service Commission Act

26-9f-101 Title.

This chapter is known as the "Utah Digital Health Service Commission Act."

Amended by Chapter 33, 2004 General Session

26-9f-102 Definitions.

As used in this chapter:

(1) "Commission" means the Utah Digital Health Service Commission created in Section 26-9f-103.

(2) "Digital health service" means the electronic transfer, exchange, or management of related data for diagnosis, treatment, consultation, educational, public health, or other related purposes.

Amended by Chapter 46, 2008 General Session

26-9f-103 Utah Digital Health Service Commission.

(1) There is created within the department the Utah Digital Health Service Commission.

(2) The governor shall appoint 13 members to the commission with the consent of the Senate, as follows:

(a) a physician who is involved in digital health service;

(b) a representative of a health care system or a licensed health care facility as that term is defined in Section 26-21-2;
(c) a representative of rural Utah, which may be a person nominated by an advisory committee on rural health issues created pursuant to Section 26-1-20;
(d) a member of the public who is not involved with digital health service;
(e) a nurse who is involved in digital health service; and
(f) eight members who fall into one or more of the following categories:
(i) individuals who use digital health service in a public or private institution;
(ii) individuals who use digital health service in serving medically underserved populations;
(iii) nonphysician health care providers involved in digital health service;
(iv) information technology professionals involved in digital health service;
(v) representatives of the health insurance industry;
(vi) telehealth digital health service consumer advocates; and
(vii) individuals who use digital health service in serving mental or behavioral health populations.

(3)
(a) The commission shall annually elect a chairperson from its membership. The chairperson shall report to the executive director of the department.
(b) The commission shall hold meetings at least once every three months. Meetings may be held from time to time on the call of the chair or a majority of the board members.
(c) Seven commission members are necessary to constitute a quorum at any meeting and, if a quorum exists, the action of a majority of members present shall be the action of the commission.

(4)
(a) Except as provided in Subsection (4)(b), a commission member shall be appointed for a three-year term and eligible for two reappointments.
(b) Notwithstanding Subsection (4)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of commission members are staggered so that approximately 1/3 of the commission is appointed each year.
(c) A commission member shall continue in office until the expiration of the member's term and until a successor is appointed, which may not exceed 90 days after the formal expiration of the term.
(d) Notwithstanding Subsection (4)(c), a commission member who fails to attend 75% of the scheduled meetings in a calendar year shall be disqualified from serving.
(e) When a vacancy occurs in membership for any reason, the replacement shall be appointed for the unexpired term.

(5) A member may not receive compensation or benefits for the member's service, but, at the executive director's discretion, 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.

(6) The department shall provide informatics staff support to the commission.

(7) The funding of the commission shall be a separate line item to the department in the annual appropriations act.

Amended by Chapter 125, 2018 General Session

26-9f-104 Duties and responsibilities.

The commission shall:
(1) advise and make recommendations on digital health service issues to the department and other state entities;
(2) advise and make recommendations on digital health service related patient privacy and information security to the department;
(3) promote collaborative efforts to establish technical compatibility, uniform policies, privacy features, and information security to meet legal, financial, commercial, and other societal requirements;
(4) identify, address, and seek to resolve the legal, ethical, regulatory, financial, medical, and technological issues that may serve as barriers to digital health service;
(5) explore and encourage the development of digital health service systems as a means of reducing health care costs and increasing health care quality and access, with emphasis on assisting rural health care providers and special populations with access to or development of electronic medical records;
(6) seek public input on digital health service issues; and
(7) in consultation with the department, advise the governor and Legislature on:
(a) the role of digital health service in the state;
(b) the policy issues related to digital health service;
(c) the changing digital health service needs and resources in the state; and
(d) state budgetary matters related to digital health service.

Amended by Chapter 125, 2018 General Session

Chapter 10
Family Health Services

26-10-1 Definitions.
As used in this chapter:
(1) "Down syndrome" means a genetic condition associated with an extra chromosome 21, in whole or in part, or an effective trisomy for chromosome 21.
(2) "Maternal and child health services" means:
(a) the provision of educational, preventative, diagnostic, and treatment services, including medical care, hospitalization, and other institutional care and aftercare, appliances, and facilitating services directed toward reducing infant mortality and improving the health of mothers and children provided, however, that nothing in this Subsection (2) shall be construed to allow any agency of the state to interfere with the rights of the parent of an unmarried minor in decisions about the providing of health information or services;
(b) the development, strengthening, and improvement of standards and techniques relating to the services and care;
(c) the training of personnel engaged in the provision, development, strengthening, or improvement of the services and care; and
(d) necessary administrative services connected with Subsections (2)(a), (b), and (c).
(3) "Minor" means a person under the age of 18.
(4) "Services to children with disabilities" means:
(a) the early location of children with a disability, provided that any program of prenatal diagnosis for the purpose of detecting the possible disease or disabilities of an unborn child will not

be used for screening, but rather will be utilized only when there are medical or genetic indications that warrant diagnosis;
(b) the provision for children described in Subsection (4)(a), of preventive, diagnosis, and treatment services, including medical care, hospitalization, and other institutional care and aftercare, appliances, and facilitating services directed toward the diagnosis of the condition of those children or toward the restoration of the children to maximum physical and mental health;
(c) the development, strengthening, and improvement of standards and techniques relating to services and care described in this Subsection (4);
(d) the training of personnel engaged in the provision, development, strengthening, or improvement of services and care described in this Subsection (4); and
(e) necessary administrative services connected with Subsections (4)(a), (b), and (c).

Amended by Chapter 124, 2019 General Session

26-10-2 Maternal and child health provided by department.

The department shall, as funding permits, provide for maternal and child health services and services for children with a disability if the individual needs the services and the individual cannot reasonably obtain the services from other sources.

Amended by Chapter 147, 2011 General Session
Amended by Chapter 366, 2011 General Session, (Coordination Clause)
Amended by Chapter 366, 2011 General Session

26-10-3 Director of family health services programs.

The executive director may appoint a director of family health services programs who shall be a board certified pediatrician or obstetrician with at least two years experience in public health programs.

Enacted by Chapter 126, 1981 General Session

26-10-4 State plan for maternal and child health services.

The department shall prepare and submit a state plan for maternal and child health services as required by Title II of the Public Health Services Act. The plan shall be the official state plan for the state and shall be used as the basis for administration of Title V programs within the state.

Enacted by Chapter 126, 1981 General Session

26-10-5 Plan for school health services.

The department shall establish a plan for school health services for pupils in elementary and secondary schools. The department shall cooperate with the State Board of Education and local health departments in developing such plan and shall coordinate activities between these agencies. The plan may provide for the delivery of health services by and through intermediate and local school districts and local health departments.

Amended by Chapter 144, 2016 General Session

26-10-5.5 Child literacy -- Distribution of information kits.

(1) The Legislature recognizes that effective child literacy programs can have a dramatic long-term impact on each child's ability to:
(a) succeed in school;
(b) successfully compete in a global society; and
(c) become a productive, responsible citizen.
(2)
(a) To help further this end, the department may make available to parents of new-born infants, as a resource, an information kit regarding child development, the development of emerging literacy skills, and activities which promote and enhance emerging literacy skills, including reading aloud to the child on a regular basis.
(b) The department shall seek private funding to help support this program.
(3)
(a) The department may seek assistance from the State Board of Education and local hospitals in making the information kit available to parents on a voluntary basis.
(b) The department may also seek assistance from private entities in making the kits available to parents.

Amended by Chapter 144, 2016 General Session

26-10-6 Testing of newborn infants.

(1) Except in the case where parents object on the grounds that they are members of a specified, well-recognized religious organization whose teachings are contrary to the tests required by this section, a newborn infant shall be tested for:
(a) phenylketonuria (PKU);
(b) other heritable disorders which may result in an intellectual or physical disability or death and for which:
(i) a preventive measure or treatment is available; and
(ii) there exists a reliable laboratory diagnostic test method;
(c)
(i) an infant born in a hospital with 100 or more live births annually, hearing loss; and
(ii) an infant born in a setting other than a hospital with 100 or more live births annually, hearing loss; and
(d) critical congenital heart defects using pulse oximetry.
(2) In accordance with Section 26-1-6, the department may charge fees for:
(a) materials supplied by the department to conduct tests required under Subsection (1);
(b) tests required under Subsection (1) conducted by the department;
(c) laboratory analyses by the department of tests conducted under Subsection (1); and
(d) the administrative cost of follow-up contacts with the parents or guardians of tested infants.
(3) Tests for hearing loss described in Subsection (1) shall be based on one or more methods approved by the Newborn Hearing Screening Committee, including:
(a) auditory brainstem response;
(b) automated auditory brainstem response; and
(c) evoked otoacoustic emissions.
(4) Results of tests for hearing loss described in Subsection (1) shall be reported to:
(a) the department; and
(b) when results of tests for hearing loss under Subsection (1) suggest that additional diagnostic procedures or medical interventions are necessary:
(i) a parent or guardian of the infant;

(ii) an early intervention program administered by the department in accordance with Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Sec. 1431 et seq.; and
(iii) the Utah Schools for the Deaf and the Blind, created in Section 53E-8-201.
(5)
(a) There is established the Newborn Hearing Screening Committee.
(b) The committee shall advise the department on:
(i) the validity and cost of newborn infant hearing loss testing procedures; and
(ii) rules promulgated by the department to implement this section.
(c) The committee shall be composed of at least 11 members appointed by the executive director, including:
(i) one representative of the health insurance industry;
(ii) one pediatrician;
(iii) one family practitioner;
(iv) one ear, nose, and throat specialist nominated by the Utah Medical Association;
(v) two audiologists nominated by the Utah Speech-Language-Hearing Association;
(vi) one representative of hospital neonatal nurseries;
(vii) one representative of the Early Intervention Baby Watch Program administered by the department;
(viii) one public health nurse;
(ix) one consumer; and
(x) the executive director or the executive director's designee.
(d) Of the initial members of the committee, the executive director shall appoint as nearly as possible half to two-year terms and half to four-year terms. Thereafter, appointments shall be for four-year terms except:
(i) for those members who have been appointed to complete an unexpired term; and
(ii) as necessary to ensure that as nearly as possible the terms of half the appointments expire every two years.
(e) A majority of the members constitute a quorum, and a vote of the majority of the members present constitutes an action of the committee.
(f) The committee shall appoint a chairman from the committee's membership.
(g) The committee shall meet at least quarterly.
(h) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
(i) Section 63A-3-106;
(ii) Section 63A-3-107; and
(iii) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.
(i) The department shall provide staff for the committee.
(6) Before implementing the test required by Subsection (1)(d), the department shall conduct a pilot program for testing newborns for critical congenital heart defects using pulse oximetry. The pilot program shall include the development of:
(a) appropriate oxygen saturation levels that would indicate a need for further medical follow-up; and
(b) the best methods for implementing the pulse oximetry screening in newborn care units.

Amended by Chapter 415, 2018 General Session

26-10-7 Dental health programs -- Appointment of director.

The department shall establish and promote programs to protect and improve the dental health of the public. The executive director shall appoint a director of the dental health program who shall be a dentist licensed in the state with at least one year of training in an accredited school of public health or not less than two years of experience in public health dentistry.

Enacted by Chapter 126, 1981 General Session

26-10-8 Request for proposal required for non-state supplied services.

(1) Funds provided to the department through Sections 51-9-201 and 59-14-204 to be used to provide services, shall be awarded to non-governmental entities based on a competitive process consistent with Title 63G, Chapter 6a, Utah Procurement Code.
(2) Beginning July 1, 2010, and not more than every five years thereafter, the department shall issue requests for proposals for new or renewing contracts to award funding for programs under Subsection (1).

Amended by Chapter 347, 2012 General Session

26-10-9 Immunizations -- Consent of minor to treatment.

(1) This section:
  (a) is not intended to interfere with the integrity of the family or to minimize the rights of parents or children; and
  (b) applies to a minor, who at the time care is sought is:
    (i) married or has been married;
    (ii) emancipated as provided for in Section 78A-6-805;
    (iii) a parent with custody of a minor child; or
    (iv) pregnant.
(2)
  (a) A minor described in Subsections (1)(b)(i) and (ii) may consent to:
    (i) vaccinations against epidemic infections and communicable diseases as defined in Section 26-6-2; and
    (ii) examinations and vaccinations required to attend school as provided in Title 53G, Public Education System -- Local Administration.
  (b) A minor described in Subsections (1)(b)(iii) and (iv) may consent to the vaccinations described in Subsections (2)(a)(i) and (ii), and the vaccine for human papillomavirus only if:
    (i) the minor represents to the health care provider that the minor is an abandoned minor as defined in Section 76-5-109; and
    (ii) the health care provider makes a notation in the minor's chart that the minor represented to the health care provider that the minor is an abandoned minor under Section 76-5-109.
  (c) Nothing in Subsection (2)(a) or (b) requires a health care provider to immunize a minor.
(3) The consent of the minor pursuant to this section:
  (a) is not subject to later disaffirmance because of the minority of the person receiving the medical services;
  (b) is not voidable because of minority at the time the medical services were provided;
  (c) has the same legal effect upon the minor and the same legal obligations with regard to the giving of consent as consent given by a person of full age and capacity; and
  (d) does not require the consent of any other person or persons to authorize the medical services described in Subsections (2)(a) and (b).

(4) A health care provider who provides medical services to a minor in accordance with the provisions of this section is not subject to civil or criminal liability for providing the services described in Subsections (2)(a) and (b) without obtaining the consent of another person prior to rendering the medical services.
(5) This section does not remove the requirement for parental consent or notice when required by Section 76-7-304 or 76-7-304.5.
(6) The parents, parent, or legal guardian of a minor who receives medical services pursuant to Subsections (2)(a) and (b) are not liable for the payment for those services unless the parents, parent, or legal guardian consented to the medical services.

Amended by Chapter 415, 2018 General Session
Amended by Chapter 344, 2017 General Session

26-10-10 Cytomegalovirus (CMV) public education and testing.
(1) As used in this section "CMV" means cytomegalovirus.
(2) The department shall establish and conduct a public education program to inform pregnant women and women who may become pregnant regarding:
  (a) the incidence of CMV;
  (b) the transmission of CMV to pregnant women and women who may become pregnant;
  (c) birth defects caused by congenital CMV;
  (d) methods of diagnosing congenital CMV; and
  (e) available preventative measures.
(3) The department shall provide the information described in Subsection (2) to:
  (a) child care programs licensed under Title 26, Chapter 39, Utah Child Care Licensing Act, and their employees;
  (b) a person described in Subsection 26-39-403(1)(c) and Subsections 26-39-403(2)(a), (b), (c), (e), and (f);
  (c) a person serving as a school nurse under Section 53G-9-204;
  (d) a person offering health education in a school district;
  (e) health care providers offering care to pregnant women and infants; and
  (f) religious, ecclesiastical, or denominational organizations offering children's programs as a part of worship services.
(4) If a newborn infant fails the newborn hearing screening test(s) under Subsection 26-10-6(1), a medical practitioner shall:
  (a) test the newborn infant for CMV before the newborn is 21 days of age, unless a parent of the newborn infant objects; and
  (b) provide to the parents of the newborn infant information regarding:
    (i) birth defects caused by congenital CMV; and
    (ii) available methods of treatment.
(5) The department shall provide to the family and the medical practitioner, if known, information regarding the testing requirements under Subsection (4) when providing results indicating that an infant has failed the newborn hearing screening test(s) under Subsection 26-10-6(1).
(6) The department may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to administer the provisions of this section.

Amended by Chapter 58, 2018 General Session
Amended by Chapter 281, 2018 General Session
Amended by Chapter 415, 2018 General Session

26-10-11 Children's Hearing Aid Program.

(1) The department shall offer a program to provide hearing aids to children who qualify under this section.

(2) The department shall provide hearing aids to a child who:

(a) is younger than six years old;

(b) is a resident of Utah;

(c) has been diagnosed with hearing loss by:

(i) an audiologist with pediatric expertise; and

(ii) a physician or physician assistant;

(d) provides documentation from an audiologist with pediatric expertise certifying that the child needs hearing aids;

(e) has obtained medical clearance by a medical provider for hearing aid fitting;

(f) does not qualify to receive a contribution that equals the full cost of a hearing aid from the state's Medicaid program or the Utah Children's Health Insurance Program; and

(g) meets the financial need qualification criteria established by the department by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for participation in the program.

(3)

(a) There is established the Children's Hearing Aid Advisory Committee.

(b) The committee shall be composed of five members appointed by the executive director, and shall include:

(i) one audiologist with pediatric expertise;

(ii) one speech language pathologist;

(iii) one teacher, certified under Title 53E, Public Education System -- State Administration, as a teacher of the deaf or a listening and spoken language therapist;

(iv) one ear, nose, and throat specialist; and

(v) one parent whose child:

(A) is six years old or older; and

(B) has hearing loss.

(c) A majority of the members constitutes a quorum.

(d) A vote of the majority of the members, with a quorum present, constitutes an action of the committee.

(e) The committee shall elect a chair from its members.

(f) The committee shall:

(i) meet at least quarterly;

(ii) recommend to the department medical criteria and procedures for selecting children who may qualify for assistance from the account; and

(iii) review rules developed by the department.

(g) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with Sections 63A-3-106 and 63A-3-107 and rules made by the Division of Finance, pursuant to Sections 63A-3-106 and 63A-3-107.

(h) The department shall provide staff to the committee.

(4)

(a) There is created within the General Fund a restricted account known as the "Children's Hearing Aid Program Restricted Account."

(b) The Children's Hearing Aid Program Restricted Account shall consist of:

(i) amounts appropriated to the account by the Legislature; and

(ii) gifts, grants, devises, donations, and bequests of real property, personal property, or services, from any source, or any other conveyance that may be made to the account from private sources.

(c) Upon appropriation, all actual and necessary operating expenses for the committee described in Subsection (3) shall be paid by the account.

(d) Upon appropriation, no more than 9% of the account money may be used for the department's expenses.

(e) If this account is repealed in accordance with Section 63I-1-226, any remaining assets in the account shall be deposited into the General Fund.

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

(a) identifying the children who are financially eligible to receive services under the program; and

(b) reviewing and paying for services provided to a child under the program.

(6) The department shall, before December 1 of each year, submit a report to the Health and Human Services Interim Committee that describes the operation and accomplishments of the program.

Amended by Chapter 349, 2019 General Session

26-10-13 Reporting results of a test for hearing loss.

(1) As used in this section, "health care provider" means the same as that term is defined in Section 78B-3-403.

(2) Except as provided in Subsection (3), a health care provider shall report results of a test for hearing loss to the Utah Schools for the Deaf and the Blind if:

(a) the results suggest that additional diagnostic procedures or medical interventions are necessary; and

(b) the individual tested for hearing loss is under the age of 22.

(3) A health care provider may not make the report of an individual's results described in Subsection (2) if the health care provider receives a request to not make the report from:

(a) the individual, if the individual is not a minor; or

(b) the individual's parent or guardian, if the individual is a minor.

Enacted by Chapter 351, 2017 General Session

26-10-14 Down syndrome diagnosis -- Information and support.

(1) The department shall provide contact information for state and national Down syndrome organizations that are nonprofit and that provide information and support services for parents, including first-call programs and information hotlines specific to Down syndrome, resource centers or clearinghouses, and other education and support programs for Down syndrome.

(2) The department shall:

(a) post the information described in Subsection (1) on the department's website; and

(b) create an informational support sheet with the information described in Subsection (1) and the web address described in Subsection (2)(a).

(3) A Down syndrome organization may request that the department include the organization's informational material and contact information on the website. The department may add the information to the website, if the information meets the description under Subsection (1).

(4) Upon request, the department shall provide a health care facility or health care provider a copy of the informational support sheet described in Subsection (2)(b) to give to a pregnant woman

after the result of a prenatal screening or diagnostic test indicates the unborn child has or may have Down syndrome.

Enacted by Chapter 124, 2019 General Session

Chapter 10b
Access to Health Care

26-10b-101 Definitions.

As used in this chapter:

(1) "Committee" means the Primary Care Grant Committee created in Section 26-1-7 and described in Section 26-10b-106.

(2) "Community based organization":

(a) means a private entity; and

(b) includes for profit and not for profit entities.

(3) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or profession and enables that system, agency, or profession to work effectively in cross-cultural situations.

(4) "Executive director" means the executive director of the department.

(5) "Health literacy" means the degree to which an individual has the capacity to obtain, process, and understand health information and services needed to make appropriate health decisions.

(6) "Institutional capacity" means the ability of a community based organization to implement public and private contracts.

(7) "Medically underserved population" means the population of an urban or rural area or a population group that the committee determines has a shortage of primary health care.

(8) "Primary care grant" means a grant awarded by the department under Subsection 26-10b-102(1).

(9)

(a) "Primary health care" means:

(i) basic and general health care services given when a person seeks assistance to screen for or to prevent illness and disease, or for simple and common illnesses and injuries; and

(ii) care given for the management of chronic diseases.

(b) "Primary health care" includes:

(i) services of physicians, nurses, physician's assistants, and dentists licensed to practice in this state under Title 58, Occupations and Professions;

(ii) diagnostic and radiologic services;

(iii) preventive health services including perinatal services, well-child services, and other services that seek to prevent disease or its consequences;

(iv) emergency medical services;

(v) preventive dental services; and

(vi) pharmaceutical services.

(10) "Program" means the primary care grant program created under this chapter.

Amended by Chapter 384, 2014 General Session

26-10b-102 Department to award grants -- Applications.

(1) Within appropriations specified by the Legislature for this purpose, the department may, in accordance with the recommendation of the committee, award a grant to a public or nonprofit entity to provide primary health care to a medically underserved population.
(2) When awarding a grant under Subsection (1), the department shall, in accordance with the committee's recommendation, consider:
  (a) the content of a grant application submitted to the department;
  (b) whether an application is submitted in the manner and form prescribed by the department; and
  (c) the criteria established in Section 26-10b-103.
(3) The application for a grant under Subsection (2)(a) shall contain:
  (a) a requested award amount;
  (b) a budget; and
  (c) a narrative plan of the manner in which the applicant intends to provide the primary health care described in Subsection (1).

Amended by Chapter 384, 2014 General Session

26-10b-103 Content of grant applications.

An applicant for a grant under this chapter shall include, in an application:
(1) a statement of specific, measurable objectives, and the methods the applicant will use to assess the achievement of those objectives;
(2) the precise boundaries of the area the applicant will serve, including a description of the medically underserved population the applicant will serve using the grant;
(3) the results of a need assessment that demonstrates that the population the applicant will serve has a need for the services provided by the applicant;
(4) a description of the personnel responsible for carrying out the activities of the grant along with a statement justifying the use of any grant funds for the personnel;
(5) evidence that demonstrates the applicant's existing financial and professional assistance and any attempts by the applicant to obtain financial and professional assistance;
(6) a list of services the applicant will provide;
(7) the schedule of fees, if any, the applicant will charge;
(8) the estimated number of individuals the applicant will serve with the grant award; and
(9) any other information required by the department in consultation with the committee.

Amended by Chapter 384, 2014 General Session

26-10b-104 Process and criteria for awarding primary care grants.

(1) The department shall review and rank applications based on the criteria in this section and transmit the applications to the committee for review.
(2) The committee shall, after reviewing the applications transferred to the committee under Subsection (1), make recommendations to the executive director.
(3) The executive director shall, in accordance with the committee's recommendations, decide which applications to award grants under Subsection 26-10b-102(1).
(4) The department shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, governing the application form, the process, and the criteria the department will use in reviewing, ranking, and awarding grants and contracts under this chapter.

(5) When reviewing, ranking, and awarding a primary care grant under Subsection 26-10b-102(1), the department shall consider the extent to which an applicant:
(a) demonstrates that the area or a population group the applicant will serve under the application has a shortage of primary health care and that the primary health care will be located so that it provides assistance to the greatest number of individuals in the population group;
(b) utilizes other sources of funding, including private funding, to provide primary health care;
(c) demonstrates the ability and expertise to serve a medically underserved population;
(d) agrees to submit a report to the committee annually; and
(e) meets other criteria determined by the department in consultation with the committee.
(6) The department may use up to 5% of the funds appropriated by the Legislature to the primary care grant program under this chapter to pay the costs of administering the program.

Amended by Chapter 384, 2014 General Session

26-10b-106 Primary Care Grant Committee.
(1) The Primary Care Grant Committee created in Section 26-1-7 shall:
(a) review grant applications forwarded to the committee by the department under Subsection 26-10b-104(1);
(b) recommend, to the executive director, grant applications to award under Subsection 26-10b-102(1);
(c) evaluate:
(i) the need for primary health care in different areas of the state;
(ii) how the program is addressing those needs; and
(iii) the overall effectiveness and efficiency of the program;
(d) review annual reports from primary care grant recipients;
(e) meet as necessary to carry out its duties, or upon a call by the committee chair or by a majority of committee members; and
(f) make rules, with the concurrence of the department, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that govern the committee, including the committee's grant selection criteria.
(2) The committee shall consist of:
(a) as chair, the executive director or an individual designated by the executive director; and
(b) six members appointed by the governor to serve up to two consecutive, two-year terms of office, including:
(i) four licensed health care professionals; and
(ii) two community advocates who are familiar with a medically underserved population and with health care systems, where at least one is familiar with a rural medically underserved population.
(3) The executive director may remove a committee member:
(a) if the member is unable or unwilling to carry out the member's assigned responsibilities; or
(b) for a rational reason.
(4) A committee member may not receive compensation or benefits for the member's service, except a committee member who is not an employee of the department 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 in accordance with Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 74, 2016 General Session

26-10b-107 Community education and outreach contracts.

(1) The department may, as funding permits, contract with community based organizations for the purpose of developing culturally and linguistically appropriate programs and services for low income and medically underserved populations to accomplish one or more of the following:
  (a) to educate individuals:
    (i) to use private and public health care coverage programs, products, services, and resources in a timely, effective, and responsible manner;
    (ii) to pursue preventive health care, health screenings, and disease management; and
    (iii) to locate health care programs and services;
  (b) to assist individuals to develop:
    (i) personal health management;
    (ii) self-sufficiency in daily care; and
    (iii) life and disease management skills;
  (c) to support translation of health materials and information;
  (d) to facilitate an individual's access to primary care and providers, including mental health services; and
  (e) to measure and report empirical results of the pilot project.

(2) When awarding a contract for community based services under Subsection (1), the department shall consider the extent to which the applicant:
  (a) demonstrates that the area or a population group to be served under the application is a medically underserved population and that the services will be located to provide assistance to the greatest number of individuals residing in the area or included in the population group;
  (b) utilizes other sources of funding, including private funding, to provide the services described in Subsection (1);
  (c) demonstrates the ability and expertise to serve medically underserved populations, including individuals with limited English-speaking ability, single heads of households, the elderly, individuals with low income, and individuals with a chronic disease;
  (d) meets other criteria determined by the department; and
  (e) demonstrates the ability to empirically measure and report the results of all contract supported activities.

(3) The department may only award a contract under Subsection (1):
  (a) in accordance with Title 63G, Chapter 6a, Utah Procurement Code;
  (b) that contains the information described in Section 26-10b-103, relating to grants; and
  (c) that complies with Subsections (4) and (5).

(4) An applicant under this chapter shall demonstrate to the department that the applicant will not deny services to a person because of the person's inability to pay for the services.

(5) Subsection (4) does not preclude an applicant from seeking payment from the person receiving services, a third party, or a government agency if:
  (a) the applicant is authorized to charge for the services; and
  (b) the person, third party, or government agency is under legal obligation to pay for the services.

(6) The department shall maximize the use of federal matching funds received for services under Subsection (1) to fund additional contracts under Subsection (1).

Enacted by Chapter 384, 2014 General Session

Chapter 15
General Sanitation

26-15-1 Definitions.

As used in this chapter:

(1)

(a) "Food handler" means any person working part-time or full-time in a food service establishment who moves food or food containers, prepares, stores, or serves food; comes in contact with any food, utensil, tableware or equipment; or washes the same. The term also includes owners, supervisors, and management persons, and any other person working in a food-service establishment. The term also includes any operator or person employed by one who handles food dispensed through vending machines; or who comes into contact with food contact surfaces or containers, equipment, utensils, or packaging materials used in connection with vending machine operations; or who otherwise services or maintains one or more vending machines.

(b) "Food handler" does not include a producer of food products selling food at a farmers market as defined in Subsection 4-5-102(5).

(2) "Pest" means a noxious, destructive, or troublesome organism whether plant or animal, when found in and around places of human occupancy, habitation, or use which threatens the public health or well being of the people within the state.

(3) "Vector" means any organism, such as insects or rodents, that transmits a pathogen that can affect public health.

Amended by Chapter 345, 2017 General Session

26-15-2 Minimum rules of sanitation established by department.

The department shall establish and enforce, or provide for the enforcement of minimum rules of sanitation necessary to protect the public health. Such rules shall include, but not be limited to, rules necessary for the design, construction, operation, maintenance, or expansion of:

(1) restaurants and all places where food or drink is handled, sold or served to the public;
(2) public swimming pools;
(3) public baths including saunas, spas, massage parlors, and suntan parlors;
(4) public bathing beaches;
(5) schools which are publicly or privately owned or operated;
(6) recreational resorts, camps, and vehicle parks;
(7) amusement parks and all other centers and places used for public gatherings;
(8) mobile home parks and highway rest stops;
(9) construction or labor camps;
(10) jails, prisons and other places of incarceration or confinement;
(11) hotels and motels;
(12) lodging houses and boarding houses;
(13) service stations;
(14) barbershops and beauty shops;
(15) physician and dentist offices;
(16) public buildings and grounds;
(17) public conveyances and terminals; and

(18) commercial tanning facilities.

Amended by Chapter 25, 2007 General Session

26-15-3 Department to advise regarding the plumbing code.

(1) The department shall advise the Division of Occupational and Professional Licensing and the Uniform Building Code Commission with respect to the adoption of a state construction code under Section 15A-1-204, including providing recommendations as to:
  (a) a specific edition of a plumbing code issued by a nationally recognized code authority; and
  (b) any amendments to a nationally recognized code.
(2) The department may enforce the plumbing code adopted under Section 15A-1-204.
(3) Section 58-56-9 does not apply to health inspectors acting under this section.

Amended by Chapter 14, 2011 General Session

26-15-4 Rules for wastewater disposal systems.

The department shall establish rules necessary to protect the public health for the design, and construction, operation and maintenance of individual wastewater disposal systems.

Enacted by Chapter 126, 1981 General Session

26-15-5 Requirements for food handlers -- Training program and testing requirements for permit -- Rulemaking.

(1) As used in this section:
  (a) "Approved food handler training program" means a training program described by this section and approved by the department.
  (b) "Food handler" means a person who works with unpackaged food, food equipment or utensils, or food-contact surfaces for a food service establishment.
  (c) "Food handler permit" means a permit issued by a local health department to allow a person to work as a food handler.
  (d) "Food service establishment" has the same meaning as provided in Section 26-15a-102.
  (e) "Provider" means a person or entity that provides an approved food handler training program.
(2) A person may not work as a food handler for a food service establishment unless the person:
  (a) successfully completes an approved food handler training program within 14 days after the day on which the person begins employment that includes food handler services; and
  (b) obtains a food handler permit within 30 days after the day on which the person begins employment that includes food handler services.
(3) An approved food handler training program shall include:
  (a) at least 75 minutes of training time;
  (b) an exam, which requires a passing score of 75% and, except as provided in Subsection (11), consists of:
    (i) 40 multiple-choice questions developed by the department, in consultation with local health departments; and
    (ii) four content sections designated by rule of the department with 10 randomly selected questions for each content section; and
  (c) upon completion, the awarding of a certificate of completion that is valid with any local health department in the state for 30 days after the day on which the certificate is issued:
    (i) to a student who:

(A) completes the training; and
(B) passes the exam described in this Subsection (3) or an exam approved by the department in accordance with Subsection (11); and
(ii) which certificate of completion:
(A) includes student identifying information determined by department rule; and
(B) is delivered by mail or electronic means.
(4)
(a) A person may obtain a food handler permit by:
(i) providing a valid certificate of completion of an approved food handler training program and an application, approved by the local health department, to a local health department; and
(ii) paying a food handler permit fee to the local health department.
(b)
(i) A local health department may charge a food handler permit fee that is reasonable and that reflects the cost of managing the food safety program.
(ii) The department shall establish by rule the maximum amount a local health department may charge for the fee described in Subsection (4)(b)(i).
(5) A person working as a food handler for a food service establishment shall obtain a food handler permit:
(a) before handling any food;
(b) within 30 days of initial employment with a food service establishment; and
(c) within seven days of the expiration of an existing food handler permit.
(6)
(a) A person who holds a valid food handler permit under this section may serve as a food handler throughout the state without restriction.
(b) A food handler permit granted after June 30, 2013, is valid for three years from the date of issuance.
(7) A person may not serve as an instructor of an approved food handler training program, unless the person is registered with a local health department as an instructor.
(8) The department, in consultation with local health departments, shall:
(a) approve the content of an approved food handler training program required under Subsection (3);
(b) approve, as qualified, each provider; and
(c) in accordance with applicable rules made under Subsection (12), provide a means to authenticate:
(i) documents used in an approved food handler training program;
(ii) the identity of an approved instructor; and
(iii) an approved provider.
(9) An approved food handler training program shall:
(a) provide basic instruction on the Centers for Disease Control and Prevention's top five foodborne illness risk factors, including:
(i) improper hot and cold holding temperatures of potentially hazardous food;
(ii) improper cooking temperatures of food;
(iii) dirty or contaminated utensils and equipment;
(iv) poor employee health and hygiene; and
(v) food from unsafe sources;
(b) be offered through:
(i) a trainer-led class;
(ii) the Internet; or

(iii) a combination of a trainer-led class and the Internet;

(c) maintain a system to verify a certificate of completion of an approved food handler training program issued under Subsection (3) to the department, a local health department, and a food service establishment; and

(d) provide to the department unrestricted access to classroom training sessions and online course materials at any time for audit purposes.

(10)

(a) A provider that provides an approved food handler training program may charge a reasonable fee.

(b) If a person or an entity is not approved by the department to provide an approved food handler training program, the person or entity may not represent, in connection with the person's or entity's name or business, including in advertising, that the person or entity is a provider of an approved food handler training program or otherwise represent that a program offered by the person or entity will qualify an individual to work as a food handler in the state.

(11)

(a) Subject to the approval of the department every three years, a provider may use an exam that consists of questions that do not conform with the provisions of Subsection (3)(b), if:

(i) the provider complies with the provisions of this Subsection (11);

(ii) the provider pays a fee every three years to the department, which fee shall be determined by the department and shall reflect the cost of the review of the alternative test questions; and

(iii) an independent instructional design and testing expert provides a written report to the department containing a positive recommendation based on the expert's analysis as described in Subsection 11(b).

(b)

(i) A provider may request approval of a different bank of test questions other than the questions developed under Subsection (3) by submitting to the department a proposed bank of at least 200 test questions organized by learning objective in accordance with Subsection (9)(a).

(ii) A provider proposing a different bank of test questions under this Subsection (11) shall contract with an independent instructional design and testing expert approved by the department at the provider's expense to analyze the provider's bank of test questions to ensure the questions:

(A) effectively measure the applicant's knowledge of the required learning objectives; and

(B) meet the appropriate testing standards for question structure.

(c) If the department provides written notice to a provider that any test question of the provider's approved exam under this Subsection (11) inadequately tests the required learning objectives, the provider shall make required changes to the question within 30 days after the day on which written notice is received by the provider.

(d) A food handler exam offered by a provider may be:

(i) a written exam;

(ii) an online exam; or

(iii) an oral exam, if circumstances require, including when an applicant's language or reading abilities interfere with taking a written or online exam.

(e) A provider shall routinely rotate test questions from the test question bank, change the order of test questions in tests, and change the order of multiple-choice answers in test questions to discourage cheating.

(12)

(a) When exercising rulemaking authority under this section the department shall comply with the requirements of Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(b) The department shall, by rule, establish requirements designed to inhibit fraud for an approved food handler training program described in this section.
(c) The requirements described in Subsection (12)(b) may include requirements to ensure that:
(i) an individual does not attempt to complete the program or exam in another individual's place;
(ii) an individual taking the approved food handler training program is focused on training material and actively engaged throughout the training period;
(iii) if the individual is unable to participate online because of technical difficulties, an approved food handler training program provides technical support, such as requiring a telephone number, email, or other method of communication to allow an individual taking the online course or test to receive assistance;
(iv) an approved food handler training program provider maintains a system to reduce fraud as to who completes an approved food handler training program, such as requiring a distinct online certificate with information printed on the certificate that identifies a person taking an online course or exam, or requiring measures to inhibit duplication of a certificate of completion or of a food handler permit;
(v) the department may audit an approved food handler training program;
(vi) an individual taking an online course or certification exam has the opportunity to provide an evaluation of the online course or test;
(vii) an approved food handler training program provider track the Internet protocol address or similar electronic location of an individual who takes an online course or certification exam;
(viii) an individual who takes an online course or exam uses an electronic signature; or
(ix) if the approved food handler training program provider learns that a certificate of completion does not accurately reflect the identity of the individual who took the online course or certification exam, an approved food handler training program provider invalidates the certificate of completion.

Repealed and Re-enacted by Chapter 444, 2013 General Session

26-15-5.1 Exemptions to food handler requirements.

(1) The requirements of Section 26-15-5 do not apply to an individual who handles food:
(a) at an event sponsored by a charitable organization where the organization provides food to a disadvantaged group free of charge; and
(b) in compliance with rules established by the department under Subsection (2).
(2) The department may establish additional requirements, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for individuals handling food at an event sponsored by a charitable organization under Subsection (1).

Enacted by Chapter 327, 2014 General Session

26-15-7 Rules for controlling vector-borne diseases and pests.

The department shall adopt rules to provide for the protection of the public health by controlling or preventing the spread of vector-borne diseases and infections and to control or reduce pests by the elimination of insanitary conditions which may include but not be limited to breeding areas, shelter, harborage or sources of food associated with such diseases or pests.

Enacted by Chapter 126, 1981 General Session

26-15-8 Periodic evaluation of local health sanitation programs -- Minimum statewide enforcement standards -- Technical assistance.

(1) The department shall periodically evaluate the sanitation programs of local health departments to determine the levels of sanitation being maintained throughout the state.

(2)

(a) The department shall ensure that each local health department's enforcement of the minimum rules of sanitation adopted under Section 26-15-2 for restaurants and other places where food or drink is handled meets or exceeds minimum statewide enforcement standards established by the department by administrative rule.

(b) Administrative rules adopted under Subsection (2)(a) shall include at least:

(i) the minimum number of periodic on-site inspections that shall be conducted by each local health department;

(ii) criteria for conducting additional inspections; and

(iii) standardized methods to be used by local health departments to assess compliance with the minimum rules of sanitation adopted under Section 26-15-2.

(c) The department shall help local health departments comply with the minimum statewide enforcement standards adopted under this Subsection (2) by providing technical assistance.

Amended by Chapter 297, 2011 General Session

26-15-9 Impoundment of adulterated food products authorized.

The department and local health departments may impound any food products found in places where food or drink is handled, sold, or served to the public that is intended for but found to be adulterated and unfit for human consumption; and, upon five days notice and reasonable opportunity for a hearing to the interested parties, to condemn and destroy the same if deemed necessary for the protection of the public health.

Enacted by Chapter 126, 1981 General Session

26-15-11 Statutes on smoking considered public health laws.

Title 26, Chapter 38, Utah Indoor Clean Air Act, is a public health law and shall be enforced by the department and local health departments.

Amended by Chapter 281, 1994 General Session

26-15-12 Rules to implement statutes on smoking.

The department shall adopt rules necessary and reasonable to implement the provisions of Title 26, Chapter 38, Utah Indoor Clean Air Act.

Amended by Chapter 281, 1994 General Session

26-15-13 Regulation of tanning facilities.

(1) For purposes of this section:

(a) "Minor" means a person under 18 years of age.

(b) "Phototherapy device" means equipment that emits ultraviolet radiation used by a health care professional in the treatment of disease.

(c)

(i) "Tanning device" means equipment to which a tanning facility provides access that emits electromagnetic radiation with wavelengths in the air between 200 and 400 nanometers used for tanning of the skin, including:
(A) a sunlamp; and
(B) a tanning booth or bed.
(ii) "Tanning device" does not include a phototherapy device.
(d) "Tanning facility" means a commercial location, place, area, structure, or business that provides access to a tanning device.
(2) A tanning facility shall:
(a) annually obtain a permit to do business as a tanning facility from the local health department with jurisdiction over the location in which the facility is located; and
(b) in accordance with Subsection (3) post a warning sign in a conspicuous location that is readily visible to a person about to use a tanning device.
(3) The posted warning and written consent required by Subsections (2) and (5) shall be developed by the department through administrative rules and shall include:
(a) that there are health risks associated with the use of a tanning device;
(b) that the facility may not allow a minor to use a tanning device unless the minor:
(i) has a written order from a physician; or
(ii) at each time of use is accompanied at the tanning facility by a parent or legal guardian who provides written consent authorizing the minor to use the tanning device.
(4) It is unlawful for any operator of a tanning facility to allow a minor to use a tanning device unless:
(a) the minor has a written order from a physician as defined in Section 58-67-102, to use a tanning device as a medical treatment; or
(b)
(i) the minor's parent or legal guardian appears in person at the tanning facility each time that the minor uses a tanning device, except that the minor's parent or legal guardian is not required to remain at the facility for the duration of the use; and
(ii) the minor's parent or legal guardian signs the consent form required in Subsection (5).
(5) The written consent required by Subsection (4) shall be signed and dated each time the minor uses a tanning device at the facility, and shall include at least:
(a) information concerning the health risks associated with the use of a tanning device; and
(b) a statement that:
(i) the parent or legal guardian of the minor has read and understood the warnings given by the tanning facility, and consents to the minor's use of a tanning device; and
(ii) the parent or legal guardian agrees that the minor will use protective eye wear.
(6) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying:
(a) minimum requirements a tanning facility shall satisfy to obtain a permit under Subsection (2);
(b) the written information concerning health risks a facility should include in the posted signs required by Subsection (3) and in the consent form required by Subsection (5);
(c) procedures a tanning facility shall implement to ensure a minor and the minor's parent or legal guardian comply with Subsections (4) and (5), including use of a statewide uniform form:
(i) for a parent or legal guardian to certify and give consent under Subsection (5); and
(ii) that clearly identifies the department's seal or other means to indicate that the form is an official form of the department; and
(d) the size, placement, and content of the sign a tanning facility must post under Subsection (2).
(7)

(a) A violation of this section:
(i) is an infraction; and
(ii) may result in the revocation of a permit to do business as a tanning facility.
(b) If a person misrepresents to a tanning facility that the person is 18 years of age or older, the person is guilty of an infraction.
(8) This section supercedes any ordinance enacted by the governing body of a political subdivision that:
(a) imposes restrictions on access to a tanning device by a person younger than age 18 that is not essentially identical to the provisions of this section; or
(b) that require the posting of warning signs at the tanning facility that are not essentially identical to the provisions of this section.

Amended by Chapter 303, 2016 General Session

Chapter 15a
Food Safety Manager Certification Act

26-15a-101 Title.
This chapter shall be known as the "Food Safety Manager Certification Act."

Enacted by Chapter 345, 1998 General Session

26-15a-102 Definitions.
(1) "Back country food service establishment" means a federal or state licensed back country guiding or outfitting business that:
(a) provides food services; and
(b) meets department recognized federal or state food service safety regulations for food handlers.
(2) "Certified food safety manager" means a manager of a food service establishment who:
(a) passes successfully a department-approved examination;
(b) successfully completes, every three years, renewal requirements established by department rule consistent with original certification requirements; and
(c) submits to the appropriate local health department the documentation required by Section 26-15a-106.
(3) "Food service establishment" means any place or area within a business or organization where potentially hazardous foods are prepared and intended for individual portion service and consumption by the general public, whether the consumption is on or off the premises, and whether or not a fee is charged for the food.
(4) "Local health department" means a local health department as defined in Subsection 26A-1-102(5).
(5) "Potentially hazardous foods" shall be defined by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Amended by Chapter 382, 2008 General Session

26-15a-103 Duties.

In connection with this chapter:
(1) the department shall:
(a) establish, by rule:
(i) statewide, uniform standards for certified food safety managers;
(ii) criteria for food safety certification examinations; and
(iii) other provisions necessary to implement this chapter; and
(b) approve food safety certification examinations; and
(2) the local health department shall enforce the provisions of this chapter.

Enacted by Chapter 345, 1998 General Session

26-15a-104 Food service establishment requirements -- Enforcement -- Right of appeal.
(1) Each food service establishment in the state shall be managed by at least one full-time certified food safety manager at each establishment site, who need not be present at the establishment site during all its hours of operation.
(2) Within 60 days of the termination of a certified food safety manager's employment that results in the food service establishment no longer being in compliance with Subsection (1), the food service establishment shall:
(a) employ a new certified food safety manager; or
(b) designate another employee to become the establishment's certified food safety manager who shall commence a department-approved food safety manager training course.
(3) Compliance with the 60-day time period provided in Subsection (2) may be extended by the local health department for reasonable cause, as determined by the department by rule.
(4)
(a) The local health department may determine whether a food service establishment is in compliance with this section by visiting the establishment during regular business hours and requesting information and documentation about the employment of a certified food safety manager.
(b) If a violation of this section is identified, the local health department shall propose remedial action to bring the food service establishment into compliance.
(c) A food service establishment receiving notice of a violation and proposed remedial action from a local health department may appeal the notice of violation and proposed remedial action pursuant to procedures established by the local health department, which shall be essentially consistent with the provisions of Title 63G, Chapter 4, Administrative Procedures Act. Notwithstanding the provisions of Section 63G-4-402, an appeal of a local health department decision to a district court shall be conducted as an original, independent proceeding, and not as a review of the proceedings conducted by the local health department. The district court shall give no deference to the findings or conclusions of the local health department.

Amended by Chapter 382, 2008 General Session

26-15a-105 Exemptions to food service establishment requirements.
(1) The following are not subject to the provisions of Section 26-15a-104:
(a) special events sponsored by municipal or nonprofit civic organizations, including food booths at school sporting events and little league athletic events and church functions;
(b) temporary event food services approved by a local health department;

(c) vendors and other food service establishments that serve only commercially prepackaged foods and beverages as defined by the department by rule;
(d) private homes not used as a commercial food service establishment;
(e) health care facilities licensed under Chapter 21, Health Care Facility Licensing and Inspection Act;
(f) bed and breakfast establishments at which the only meal served is a continental breakfast as defined by the department by rule;
(g) residential child care providers;
(h) child care providers and programs licensed under Chapter 39, Utah Child Care Licensing Act;
(i) back country food service establishments;
(j) an event that is sponsored by a charitable organization, if, at the event, the organization:
(i) provides food to a disadvantaged group free of charge; and
(ii) complies with rules established by the department under Subsection (3); and
(k) a lowest risk or permitted food establishment category determined by a risk assessment evaluation established by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(2) Nothing in this section may be construed as exempting a food service establishment described in Subsection (1) from any other applicable food safety laws of this state.
(3) The department may establish additional requirements, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, for charitable organizations providing food for free under Subsection (1)(j).

Amended by Chapter 327, 2014 General Session

26-15a-106 Certified food safety manager.
(1) Before a person may manage a food service establishment as a certified food safety manager, that person shall submit documentation in the format prescribed by the department to the appropriate local health department indicating a passing score on a department-approved examination.
(2) To continue to manage a food service establishment, a certified food safety manager shall:
(a) successfully complete, every three years, renewal requirements established by department rule which are consistent with original certification requirements; and
(b) submit documentation in the format prescribed by the department within 30 days of the completion of renewal requirements to the appropriate local health department.
(3) A local health department may deny, revoke, or suspend the authority of a certified food safety manager to manage a food service establishment or require the completion of additional food safety training courses for any one of the following reasons:
(a) submitting information required under Subsection (1) or (2) that is false, incomplete, or misleading;
(b) repeated violations of department or local health department food safety rules; or
(c) operating a food service establishment in a way that causes or creates a health hazard or otherwise threatens the public health, safety, or welfare.
(4) A determination of a local health department made pursuant to Subsection (3) may be appealed by a certified food safety manager in the same manner provided for in Subsection 26-15a-104(4).
(5) No person may use the title "certified food safety manager," or any other similar title, unless the person has satisfied the requirements of this chapter.

Amended by Chapter 86, 2000 General Session

26-15a-107 Duties.

Certified food safety managers shall:

(1) establish and monitor compliance with practices and procedures in the food service establishments where they are employed to maintain compliance with department and local health department food safety rules; and

(2) perform such other duties that may be necessary to ensure food safety in the food service establishments where they are employed.

Enacted by Chapter 345, 1998 General Session

Chapter 18
Medical Assistance Act

Part 1
Medical Assistance Programs

26-18-1 Short title.

This chapter shall be known and may be cited as the "Medical Assistance Act."

Enacted by Chapter 126, 1981 General Session

26-18-2 Definitions.

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 Medicaid and Health Financing within the department, established under Section 26-18-2.1.

(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.

Amended by Chapter 393, 2019 General Session

26-18-2.1 Division -- Creation.

There is created, within the department, the Division of Medicaid and Health Financing 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, in accordance with the provisions of this chapter and applicable federal law.

Amended by Chapter 393, 2019 General Session

26-18-2.2 State Medicaid director -- Appointment -- Responsibilities.

The state Medicaid director shall be appointed by the governor, after consultation with the executive director, with the advice and consent of the Senate. The state Medicaid director may employ other employees as necessary to implement the provisions of this chapter, and shall:

(1) administer the responsibilities of the division as set forth in this chapter;

(2) administer the division's budget; and

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

Amended by Chapter 393, 2019 General Session

26-18-2.3 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 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 recovery.

(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.

(5) The department shall, by December 31 of each year, report to the Social Services Appropriations Subcommittee regarding:

(a) measures taken under this section to increase:

(i) efficiencies within the program; and

(ii) cost avoidance and cost recovery efforts in the program; and

(b) results of program integrity efforts under Subsection (4).

Amended by Chapter 393, 2019 General Session

26-18-2.4 Medicaid drug program -- Preferred drug list.

(1) A Medicaid drug program developed by the department under Subsection 26-18-2.3(2)(f):

(a) shall, notwithstanding Subsection 26-18-2.3(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 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) 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. 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 of Health 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 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) The department shall develop a preferred drug list for psychotropic drugs. 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. 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.

(e) The department shall report to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee before November 30, 2016, and before each November 30 thereafter regarding compliance with and savings from implementation of this Subsection (3).

Amended by Chapter 168, 2016 General Session
Amended by Chapter 279, 2016 General Session

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

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

(2)

(a) The department may enter into an agreement with a 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.

Amended by Chapter 393, 2019 General Session

26-18-2.6 Dental benefits.

(1)
(a) Except as provided in Subsection (8), the division shall 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:
(a) in 2011; and
(b) at least once every five years thereafter.

(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 the request for proposals under 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 Health and Human Services for waivers or pilot programs if necessary to establish the new dental care delivery

and payment reform model. 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.

Amended by Chapter 22, 2017 General Session

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

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

(2)

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

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

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

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

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

(iv) a requirement that:

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

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

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

(3)

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

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

(ii) initiates a new Medicaid waiver;

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

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

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

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

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

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

(ii) include:

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

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

(C) the proposed change in services or reimbursement, including a description of the effect of the change;
(D) the effect of an increase or decrease in services or benefits on individuals and families;
(E) the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and
(F) the fiscal impact of the proposed change, including:
(I) the effect of the proposed change on current or future appropriations from the Legislature to the department;
(II) the effect the proposed change may have on federal matching dollars received by the state Medicaid program;
(III) any cost shifting or cost savings within the department's budget that may result from the proposed change; and
(IV) identification of the funds that will be used for the proposed change, including any transfer of funds within the department's budget.

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

(5) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including:
(a) the determination of the eligibility of individuals for the program;
(b) recovery of overpayments; and
(c) consistent with Section 26-20-13, and to the extent permitted by law and quality control services, enforcement of fraud and abuse laws.

(6) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:
(a) termination from the program;
(b) recovery of claim reimbursements incorrectly paid; and
(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(7)
(a) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as dedicated credits to be used by the division in accordance with the requirements of Section 1919 of Title XIX of the federal Social Security Act.
(b) In accordance with Section 63J-1-602.2, sanctions collected under this Subsection (7) are nonlapsing.

(8)
(a) In determining whether an applicant or recipient is eligible for a service or benefit under this part or Chapter 40, Utah Children's Health Insurance Act, the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.
(b) Before Subsection (8)(a) may be applied:
(i) the federal government shall:
(A) determine that Subsection (8)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;
(B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or
(C) determine that the state's waivers that permit dual eligibility determinations for cash assistance and Medicaid are no longer valid; and

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

(9)

(a) For purposes of this Subsection (9):

(i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as defined in 42 U.S.C. Sec. 1382c(a)(1); and

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

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

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

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

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

(11)

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

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

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

(12)

(a)

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

(A) medically needy pregnant women;

(B) medically needy children; and

(C) medically needy parents and caretaker relatives.

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

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

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

(A) under the age of 26; and

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

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

(13)

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

(i) incarcerated; and

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

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

Amended by Chapter 104, 2019 General Session
Amended by Chapter 253, 2019 General Session

26-18-3.1 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. This demonstration project may also provide for the voluntary participation of private firms that:

(i) are newly established or marginally profitable;

(ii) do not provide health insurance to their employees;

(iii) employ predominantly low wage workers; and

(iv) are unable to obtain adequate and affordable health care insurance in the private market.

(4) The Medicaid program shall provide for eligibility for persons as required by Subsection 26-18-3.9(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.

Amended by Chapter 1, 2019 General Session

26-18-3.5 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.

Amended by Chapter 393, 2019 General Session

26-18-3.6 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.
(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, does not apply if a court has entered an order against an institutionalized spouse for the support of the community spouse.

Amended by Chapter 393, 2019 General Session

26-18-3.8 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;
(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.
(c) Any increase in state costs resulting from an expansion of premium assistance may not exceed offsetting reductions in Medicaid and Children's Health Insurance Program state costs attributable to the expansion.
(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.

Amended by Chapter 137, 2013 General Session

26-18-3.9 Expanding the Medicaid program.
(1) As used in this section:
(a) "CMS" means the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services.
(b) "Federal poverty level" means the same as that term is defined in Section 26-18-411.
(c) "Medicaid expansion" means an expansion of the Medicaid program in accordance with this section.
(d) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26-36b-208.
(2)
(a) As set forth in Subsections (2) through (5), eligibility criteria for the Medicaid program shall be expanded to cover additional low-income individuals.
(b) The department shall continue to seek approval from CMS to implement the Medicaid waiver expansion as defined in Section 26-18-415.
(c) The department may implement any provision described in Subsections 26-18-415(2)(b)(iii) through (viii) in a Medicaid expansion if the department receives approval from CMS to implement that provision.
(3) The department shall expand the Medicaid program in accordance with this Subsection (3) if the department:
(a) receives approval from CMS to:
(i) expand Medicaid coverage to eligible individuals whose income is below 95% of the federal poverty level;
(ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(b) for enrolling an individual in the Medicaid expansion under this Subsection (3); and

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

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

(i) the Medicaid Expansion Fund;

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

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

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

(4)

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

(i) receives approval from CMS to:

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

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

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

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

(A) the Medicaid Expansion Fund;

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

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

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

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

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

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

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

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

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

(5)

(a)

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

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

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

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

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

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

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

(ii) July 1, 2020.

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

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

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

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

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

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

(i) the Medicaid Expansion Fund;

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) the Division of Finance shall deposit the total amount from the reduced allotments described in Subsection (5)(g)(ii) into the Medicaid Expansion Fund.

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

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

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

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

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

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

(d) recommendations to control costs of the Medicaid expansion.

Amended by Chapter 1, 2019 General Session

26-18-4 Department standards for eligibility under Medicaid -- Funds for abortions.

(1) 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(8). 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.

Amended by Chapter 167, 2013 General Session

26-18-5 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 state agencies, contracts shall provide that other state agencies 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.

Amended by Chapter 393, 2019 General Session

26-18-6 Federal aid -- Authority of executive director.

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

Enacted by Chapter 126, 1981 General Session

26-18-7 Medical vendor rates.

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. 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.

Amended by Chapter 21, 1988 General Session

26-18-8 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 insofar as these sections pertain to benefits conferred or administered by the division under this chapter.

(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.

Amended by Chapter 90, 2003 General Session

26-18-9 Prohibited acts of state or local employees of Medicaid program -- Violation a misdemeanor.

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. Violation of this section is a class A misdemeanor.

Enacted by Chapter 126, 1981 General Session

26-18-11 Rural hospitals.

(1) For purposes of 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 may not discriminate among rural hospitals on the basis of size.

Amended by Chapter 393, 2019 General Session

26-18-13 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).

Amended by Chapter 241, 2017 General Session

26-18-13.5 Telehealth services -- Reimbursement -- Reporting -- 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.

Amended by Chapter 249, 2019 General Session

26-18-15 Process to promote health insurance coverage for children.

(1) The Department of Workforce Services, the State Board of Education, and the department shall:
(a) collaborate with one another to develop a process to promote health insurance coverage for a child in school when:
(i) the child applies for free or reduced price school lunch;
(ii) a child enrolls in or registers in school; and
(iii) other appropriate school related opportunities;
(b) report to the Legislature on the development of the process under Subsection (1)(a) no later than November 19, 2008; and
(c) implement the process developed under Subsection (1)(a) no later than the 2009-10 school year.
(2) The Department of Workforce Services shall promote and facilitate the enrollment of children identified under Subsection (1)(a) without health insurance in the Utah Children's Health Insurance Program, the Medicaid program, or the Utah Premium Partnership for Health Insurance Program.

Enacted by Chapter 390, 2008 General Session

26-18-16 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; 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 Health and Human Services if necessary to implement a plan amendment under Subsection (1)(a) or (b).

Enacted by Chapter 155, 2012 General Session

26-18-17 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; 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).

Enacted by Chapter 53, 2013 General Session

26-18-18 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; 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; 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.

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

Amended by Chapter 393, 2019 General Session

26-18-19 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.

Amended by Chapter 114, 2016 General Session

26-18-20 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 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.

Enacted by Chapter 135, 2015 General Session

26-18-21 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, 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.

Amended by Chapter 393, 2019 General Session

26-18-22 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.

Enacted by Chapter 180, 2017 General Session

26-18-23 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).

Enacted by Chapter 53, 2017 General Session

26-18-24 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.

Enacted by Chapter 180, 2018 General Session

26-18-25 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.

Enacted by Chapter 320, 2019 General Session

26-18-26 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.

Enacted by Chapter 265, 2019 General Session

Part 2
Drug Utilization Review Board

26-18-101 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) "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) "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) "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) "Drug-disease contraindications" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.
(7) "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) "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) "Intervention" means a form of communication utilized by the board with a prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

(10) "Overutilization" or "underutilization" means the use of a drug in such quantities that the desired therapeutic goal is not achieved.
(11) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act.
(12) "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) "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) "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.
(15) "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) "SURS" means the Surveillance Utilization Review System of the Medicaid program.
(17) "Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.
(18) "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.

Amended by Chapter 280, 2004 General Session

26-18-102 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.

Amended by Chapter 286, 2010 General Session
Amended by Chapter 324, 2010 General Session

26-18-103 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 an annual report, subject to public comment prior to its issuance, and submit that report to the United States Department of Health and Human Services by December 1 of each year. That report shall also be submitted to the executive director, the president of the Utah Pharmaceutical Association, and the president of the Utah Medical Association by December 1 of each year. The report shall include:
(a) an overview of the activities of the board and the DUR program;
(b) a description of interventions used and their effectiveness, specifying whether the intervention was a result of underutilization or overutilization of drugs, without disclosing the identities of individual physicians, pharmacists, or recipients;
(c) the costs of administering the DUR program;
(d) any fiscal savings resulting from the DUR program;
(e) an overview of the fiscal impact of the DUR program to other areas of the Medicaid program such as hospitalization or long-term care costs;
(f) a quantifiable assessment of whether DUR has improved the recipient's quality of care;
(g) a review of the total number of prescriptions, by drug therapeutic class;
(h) an assessment of the impact of educational programs or interventions on prescribing or dispensing practices; and
(i) recommendations for DUR program improvement;
(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.

Amended by Chapter 167, 2013 General Session

26-18-104 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(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.

Amended by Chapter 382, 2008 General Session

26-18-105 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.

Amended by Chapter 205, 2010 General Session

26-18-106 Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under this part.

Enacted by Chapter 273, 1992 General Session

26-18-107 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.

Amended by Chapter 349, 2019 General Session

26-18-108 Penalties.

Any person who violates the confidentiality provisions of this part is guilty of a class B misdemeanor.

Enacted by Chapter 273, 1992 General Session

26-18-109 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.

Enacted by Chapter 273, 1992 General Session

Part 4
Medicaid Waiver

26-18-402 Medicaid Restricted Account.

(1) There is created a restricted account in the General Fund known as the Medicaid Restricted Account.

(2)
(a) Except as provided in Subsection (3), the following shall be deposited into the Medicaid Restricted Account:
(i) any general funds appropriated to the department for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and which are not otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account;

(ii) any unused state funds that are associated with the Medicaid program, as defined in Section 26-18-2, from the Department of Workforce Services and the Department of Human Services; and
(iii) any penalties imposed and collected under:
(A) Section 17B-2a-818.5;
(B) Section 19-1-206;
(C) Section 63A-5-205.5;
(D) Section 63C-9-403;
(E) Section 72-6-107.5; or
(F) Section 79-2-404.
(b) The account shall earn interest and all interest earned shall be deposited into the account.
(c) The Legislature may appropriate money in the restricted account to fund programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.
(3) For fiscal years 2008-09, 2009-10, 2010-11, 2011-12, and 2012-13 the following funds are nonlapsing:
(a) any general funds appropriated to the department for the state plan for medical assistance, or for the Division of Health Care Financing that are not expended by the department in the fiscal year in which the general funds were appropriated; and
(b) funds described in Subsection (2)(a)(ii).

Amended by Chapter 319, 2018 General Session

26-18-403 Medicaid waiver for independent foster care adolescents.
(1) For purposes of 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 if the Division of Child and Family Services 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 to provide medical coverage for independent foster care adolescents effective fiscal year 2006-07.

Enacted by Chapter 110, 2006 General Session

26-18-404 Home and community-based long-term care -- Room and board assistance.
If the department receives approval from CMS to replace the Medicaid program's current FlexCare program with a new program to provide long-term care services in home and community-based settings rather than institutions, the department shall assist in the payment of room and board costs for any person in the new program without sufficient income to fully pay those costs.

Amended by Chapter 393, 2019 General Session

26-18-405 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.

Amended by Chapter 168, 2016 General Session
Amended by Chapter 222, 2016 General Session
Amended by Chapter 394, 2016 General Session

26-18-405.5 Base budget appropriations for Medicaid accountable care organizations.
(1) For purposes of this section:
(a) "ACOs" means accountable care organizations.
(b) "Base budget" means the same as that term is defined in legislative rule.

(c) "Current fiscal year PMPM" means per-member-per-month funding for Medicaid accountable care organizations under the Department of Health in the current fiscal year.
(d) "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.
(e) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal year ongoing General Fund revenue estimate identified by the Executive Appropriations Subcommittee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal Analyst in preparing budget recommendations.
(f) "Next fiscal year PMPM" means per-member-per-month funding for Medicaid accountable care organizations under the Department of Health for the next fiscal year.
(2) If the General Fund growth factor is less than 100%, the next fiscal year base budget shall include an appropriation to the Department of Health for Medicaid ACOs in an amount necessary to ensure that next fiscal year PMPM equals current fiscal year PMPM 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 include an appropriation to the Department of Health for Medicaid ACOs in an amount necessary to ensure that next fiscal year PMPM equals current fiscal year PMPM 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 include an appropriation to the Department of Health for Medicaid ACOs in an amount necessary to ensure that next fiscal year PMPM is greater than or equal to PMPM multiplied by 102% and less than or equal to current fiscal year PMPM multiplied by the General Fund growth factor.
(5) In order for the department to estimate the impact of Subsections (2) through (4) prior to identification of the next fiscal year ongoing General Fund revenue estimate under Subsection (1)(e), the Governor's Office of Management 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 it to the department no later than September 1 of each year.

Enacted by Chapter 288, 2015 General Session

26-18-408 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.
(b) For purposes of this section:
(i) "Accountable care organization" means a Medicaid or Children's Health Insurance Program administrator that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through an accountable care plan.
(ii) "Accountable care plan" means a risk based delivery service model authorized by Section 26-18-405 and administered by an accountable care organization.
(iii) "Nonemergent care":
(A) means use of the emergency department to receive health care that is nonemergent 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 a recipient 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 nonemergent 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 accountable care organization as a person who uses the emergency department excessively, as defined by the accountable care organization.

(2)

(a) An accountable care organization may, in accordance with Subsections (2)(b) and (c):

(i) audit emergency department services provided to a recipient enrolled in the accountable care plan to determine if nonemergent care was provided to the recipient; and

(ii) establish differential payment for emergent and nonemergent 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, an accountable 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 accountable 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) An accountable care organization shall:

(a) use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all of the recipients enrolled in the accountable 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 accountable care organization complied with this Subsection (3).

(4) The department shall:

(a) through administrative rule adopted by the department, develop quality measurements that evaluate an accountable care organization's delivery of:

(i) appropriate emergency department services to recipients enrolled in the accountable care plan;

(ii) expanded primary care and urgent care for recipients enrolled in the accountable care plan, with consideration of the accountable 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 accountable care plan members;

(b) compare the quality measures developed under Subsection (4)(a) for each accountable care organization and share the data and quality measures developed under Subsection (4)(a) with the Health Data Committee created in Chapter 33a, Utah Health Data Authority Act;
(c) apply for a Medicaid waiver and a Children's Health Insurance Program waiver with CMS, to:
(i) allow the program to charge recipients who are enrolled in an accountable care plan a higher copayment for emergency department services; and
(ii) develop, by administrative rule, an algorithm to determine assignment of new, unassigned recipients to specific accountable care plans based on the plan's performance in relation to the quality measures developed pursuant to Subsection (4)(a); and
(d) before July 1, 2015, convene representatives from the accountable care organizations, pre-paid mental health plans, an organization representing hospitals, an organization representing physicians, and a county mental health and substance abuse authority to discuss alternatives to emergency department care, including:
(i) creating increased access to primary care services;
(ii) alternative care settings for super-utilizers and individuals with behavioral health or substance abuse issues;
(iii) primary care medical and health homes that can be created and supported through enhanced federal match rates, a state plan amendment for integrated care models, or other Medicaid waivers;
(iv) case management programs that can:
(A) schedule prompt visits with primary care providers within 72 to 96 hours of an emergency department visit;
(B) help super-utilizers with behavioral health or substance abuse issues to obtain care in appropriate care settings; and
(C) assist with transportation to primary care visits if transportation is a barrier to appropriate care for the recipient; and
(v) sharing of medical records between health care providers and emergency departments for Medicaid recipients.
(5) The Health Data Committee may publish data in accordance with Chapter 33a, Utah Health Data Authority Act, which compares the quality measures for the accountable care plans.

Amended by Chapter 393, 2019 General Session

26-18-409 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.

Enacted by Chapter 174, 2014 General Session

26-18-410 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) accepts applications for the program during periods of open enrollment; and

(c) if approved by CMS:

(i) requires periodic reevaluations of an enrolled child's eligibility based on the additional eligibility criteria; and

(ii) at the time of reevaluation, allows the department to disenroll a child who does not meet the additional eligibility criteria.

(4) The department shall:

(a) seek to prioritize, in the waiver described in Subsection (2), entrance into the program based on the:

(i) complexity of a qualified child's medical condition; and

(ii) financial needs of a qualified child and the qualified child's family;

(b) convene a public process to determine:

(i) the benefits and services to offer a qualified child under the program; and

(ii) additional eligibility criteria for a qualified child;

(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 criteria in 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).

Amended by Chapter 393, 2019 General Session

26-18-411 Health coverage improvement program -- Eligibility -- Annual report -- Expansion of eligibility for adults with dependent children.

(1) For purposes of 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.

(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;

(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 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.

(c) Medicaid accountable care organizations and counties that elect to integrate care under Subsection (5)(b)(iii) shall collaborate on enrollment, engagement of patients, and coordination of services.

(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 enrollment in the health coverage improvement program, 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.

Amended by Chapter 393, 2019 General Session

26-18-413 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, licensed under Title 62A, Chapter 2, Licensure of 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 transfer money 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) During each general session of the Legislature, the department shall report to the Social Services Appropriations Subcommittee whether the University of Utah School of Dentistry will have sufficient funds to make the transfer required by Subsection (2)(f) for the current fiscal year.

(h) 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)(ii).

(i) 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.

(j) Subject to appropriations by the Legislature, and as determined by the department, the scope, amount, duration, and frequency of services may be limited.

(3) The reporting requirements of Section 26-18-3 apply to the waivers requested under Subsection (1).

(4)

(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.

(5) 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.

Amended by Chapter 60, 2019 General Session
Amended by Chapter 393, 2019 General Session

26-18-414 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.

Enacted by Chapter 307, 2017 General Session

26-18-415 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.
(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;
(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.

Amended by Chapter 1, 2019 General Session
Amended by Chapter 393, 2019 General Session

26-18-416 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.

(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, 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, 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, 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 and subject to Subsection (6)(d), 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, 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(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 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(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.

Amended by Chapter 136, 2019 General Session
Amended by Chapter 393, 2019 General Session

26-18-417 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.

(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 individuals served under the program;
(b) the cost of the program; and
(c) the effectiveness of the program, including:
(i) any savings to the state Medicaid program from reductions in enrollment;
(ii) any reduction in the number of abortions;
(iii) any reduction in the number of unintended pregnancies;
(iv) any reduction in the number of individuals requiring services from the Women, Infants, and Children Program established in 42 U.S.C. Sec. 1786; and
(v) any other costs and benefits as a result of the program.

Amended by Chapter 393, 2019 General Session

26-18-418 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 63C-18-102.
(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 63C-18-102.
(2) In consultation with the Department of Human Services and the Mental Health Crisis Line 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).

Amended by Chapter 393, 2019 General Session

26-18-419 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).

Enacted by Chapter 172, 2019 General Session

26-18-419.1 Medicaid waiver expansion for extraordinary care reimbursement.

(1) As used in this section, "personal care services" means the same as that term is defined in 42 U.S.C. Sec. 1397g(b)(6)(B).
(2) The department shall:
  (a) develop a proposal to allow the state Medicaid program to reimburse an individual who provides personal care services that constitute extraordinary care to the individual's family member who is enrolled in an existing waiver in the state; and
  (b) before November 30, 2019, report to the Social Services Appropriations Subcommittee and the Health and Human Services Interim Committee regarding the proposal described in this Subsection (2) and any recommendations for implementation of the proposal.
(3) In developing the proposal described in Subsection (2), the department shall:
  (a) review statutes, policies, and programs in other states relating to reimbursement to an individual who provides personal care services that constitute extraordinary care to the individual's family member; and
  (b) consult with:
    (i) the Department of Human Services; and
    (ii) other stakeholders, as determined by the department.

Enacted by Chapter 289, 2019 General Session

Part 5
Long Term Care Facility - Medicaid Certification

26-18-501 Definitions.

As used in this part:

(1) "Certified program" means a nursing care facility program with Medicaid certification.

(2) "Director" means the state Medicaid director appointed under Section 26-18-2.2.

(3) "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.

(4)

(a) "Nursing care facility" means the following facilities licensed by the department under Chapter 21, Health Care Facility Licensing and Inspection Act:

(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).

(5) "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.

(6) "Physical facility" means the buildings or other physical structures where a nursing care facility program is operated.

(7) "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).

(8) "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.

(9) "Urban county" means a county that is not a rural county.

Amended by Chapter 393, 2019 General Session

26-18-502 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; 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).

Amended by Chapter 276, 2016 General Session

26-18-503 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) 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;
(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) As provided in Subsection 26-18-502(2)(b), 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) Notwithstanding Subsection 26-18-504(3), if a nursing care facility does not seek Medicaid certification for a bed under Subsections (1) through (6), the department shall 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).

Amended by Chapter 136, 2019 General Session
Amended by Chapter 393, 2019 General Session

26-18-504 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 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.

Amended by Chapter 443, 2017 General Session

26-18-505 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.

(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(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(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(5), including personnel, services, contracts, and licensing of facilities under Chapter 21, Health Care Facility Licensing and Inspection Act; 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, 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 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.

Amended by Chapter 443, 2017 General Session

Part 6
Medical Assistance Accountability

26-18-601 Title.

This part is known as "Medical Assistance Accountability."

Enacted by Chapter 362, 2011 General Session

26-18-602 Definitions.

As used in this part:
(1) "Abuse" means:
(a) an action or practice that:
(i) is inconsistent with sound fiscal, business, or medical practices; and
(ii) results, or may result, in unnecessary Medicaid related costs or other medical or hospital assistance costs; or
(b) reckless or negligent upcoding.
(2) "Auditor's Office" means the Office of Internal Audit, within the department.
(3) "Fraud" means intentional or knowing:
(a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, claims, reimbursement, or practice; or
(b) deception or misrepresentation in relation to medical or hospital assistance funds, costs, claims, reimbursement, or practice.
(4) "Medical or hospital assistance" is as defined in Section 26-18-2.
(5) "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.
(6) "Waste" means overutilization of resources or inappropriate payment.

Amended by Chapter 135, 2015 General Session

26-18-603 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.

Amended by Chapter 135, 2015 General Session

26-18-604 Division duties -- Reporting.
(1) The division shall:
(a) develop and implement procedures relating to Medicaid funds and medical or hospital assistance funds to ensure that providers do not receive:
(i) duplicate payments for the same goods or services;

(ii) payment for goods or services by resubmitting a claim for which:
(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
(B) the decision to disallow the payment has become final;
(iii) payment for goods or services provided after a recipient's death, including payment for pharmaceuticals or long-term care; or
(iv) payment for transporting an unborn infant;
(b) consult with the Centers for Medicaid and Medicare Services, 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;
(c) actively seek repayment from providers for improperly used or paid:
(i) Medicaid funds; and
(ii) medical or hospital assistance funds;
(d) coordinate, track, and keep records of all division efforts to obtain repayment of the funds described in Subsection (1)(c), and the results of those efforts;
(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:
(i) tracking changes in the price of pharmaceuticals;
(ii) checking the availability and price of generic drugs;
(iii) reviewing and updating the state's maximum allowable cost list; and
(iv) comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists; and
(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.
(2) Each year, the division shall report the following to the Social Services Appropriations Subcommittee:
(a) incidents of improperly used or paid Medicaid funds and medical or hospital assistance funds;
(b) division efforts to obtain repayment from providers of the funds described in Subsection (2)(a);
(c) all repayments made of funds described in Subsection (2)(a), including the total amount recovered; and
(d) the division's compliance with the recommendations made in the December 2010 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of Legislative Auditor General.

Amended by Chapter 135, 2015 General Session

26-18-605 Utah Office of Internal Audit.

The Utah Office of Internal Audit:
(1) may not be placed within the division;
(2) shall be placed directly under, and report directly to, the executive director of the Department of Health; and
(3) shall have full access to all records of the division.

Amended by Chapter 135, 2015 General Session

Chapter 18a
Kurt Oscarson Children's Organ Transplant Coordinating Committee

26-18a-1 Definitions.

As used in this chapter:

(1) "Children" or "child" means a person under the age of 18.

(2) "Committee" means the Kurt Oscarson Children's Organ Transplant Coordinating Committee.

(3) "Restricted account" means the Kurt Oscarson Children's Organ Transplant Account created in Section 26-18a-4.

Amended by Chapter 278, 2010 General Session

26-18a-2 Creation and membership of Kurt Oscarson Children's Organ Transplant Coordinating Committee -- Expenses.

(1) There is created the Kurt Oscarson Children's Organ Transplant Coordinating Committee.

(2) The committee shall have five members representing the following:

(a) the executive director of the Department of Health or his designee;

(b) two representatives from public or private agencies and organizations concerned with providing support and financial assistance to the children and families of children who need organ transplants; and

(c) two individuals who have had organ transplants, have children who have had organ transplants, who work with families or children who have had or are awaiting organ transplants, or community leaders or volunteers who have demonstrated an interest in working with families or children in need of organ transplants.

(3)

(a) The governor shall appoint the committee members and designate the chair from among the committee members.

(b)

(i) Except as required by Subsection (3)(b)(ii), each member shall serve a four-year term.

(ii) Notwithstanding the requirements of Subsection (3)(b)(i), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of the committee members are staggered so that approximately half of the committee is appointed every two years.

(4) A member may not receive compensation or benefits for the member's service, but, at the executive director's discretion, 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.

(5) The Department of Health shall provide support staff for the committee.

Amended by Chapter 286, 2010 General Session

26-18a-3 Purpose of committee.

(1) The committee shall work to:
  (a) provide financial assistance for initial medical expenses of children who need organ transplants;
  (b) obtain the assistance of volunteer and public service organizations; and
  (c) fund activities as the committee designates for the purpose of educating the public about the need for organ donors.
(2)
  (a) The committee is responsible for awarding financial assistance funded by the restricted account.
  (b) The financial assistance awarded by the committee under Subsection (1)(a) shall be in the form of interest free loans. The committee may establish terms for repayment of the loans, including a waiver of the requirement to repay any awards if, in the committee's judgment, repayment of the loan would impose an undue financial burden on the recipient.
  (c) In making financial awards under Subsection (1)(a), the committee shall consider:
    (i) need;
    (ii) coordination with or enhancement of existing services or financial assistance, including availability of insurance or other state aid;
    (iii) the success rate of the particular organ transplant procedure needed by the child; and
    (iv) the extent of the threat to the child's life without the organ transplant.
(3) The committee may only provide the assistance described in this section to children who have resided in Utah, or whose legal guardians have resided in Utah for at least six months prior to the date of assistance under this section.
(4)
  (a) The committee may expend up to 5% of its annual appropriation for administrative costs associated with the allocation of funds from the restricted account.
  (b) The administrative costs shall be used for the costs associated with staffing the committee and for State Tax Commission costs in implementing Section 59-10-1308.

Amended by Chapter 167, 2013 General Session

26-18a-4 Creation of Kurt Oscarson Children's Organ Transplant Account.
(1) There is created a restricted account within the General Fund known as the "Kurt Oscarson Children's Organ Transplant Account." Private contributions received under this section and Section 59-10-1308 shall be deposited into the restricted account to be used only for the programs and purposes described in Section 26-18a-3.
(2) Money shall be appropriated from the restricted account to the committee in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.
(3) In addition to funds received under Section 59-10-1308, the committee may accept transfers, grants, gifts, bequests, or any money made available from any source to implement this chapter.

Amended by Chapter 278, 2010 General Session

Chapter 18b
Organ Donation Contribution Fund

26-18b-101 Organ Donation Contribution Fund created.

(1)
(a) There is created an expendable special revenue fund known as the Organ Donation Contribution Fund.
(b) The Organ Donation Contribution Fund shall consist of:
(i) private contributions;
(ii) donations or grants from public or private entities;
(iii) voluntary donations collected under Sections 41-1a-230.5 and 53-3-214.7; and
(iv) interest and earnings on fund money.
(c) The cost of administering the Organ Donation Contribution Fund shall be paid from money in the fund.

(2) The Department of Health shall:
(a) administer the funds deposited in the Organ Donation Contribution Fund; and
(b) select qualified organizations and distribute the funds in the Organ Donation Contribution Fund in accordance with Subsection (3).

(3)
(a) The funds in the Organ Donation Contribution Fund may be distributed to a selected organization that:
(i) promotes and supports organ donation;
(ii) assists in maintaining and operating a statewide organ donation registry; and
(iii) provides donor awareness education.
(b) An organization that meets the criteria of Subsections (3)(a)(i) through (iii) may apply to the Department of Health, in a manner prescribed by the department, to receive a portion of the money contained in the Organ Donation Contribution Fund.

Amended by Chapter 167, 2013 General Session
Amended by Chapter 400, 2013 General Session

Chapter 19
Medical Benefits Recovery Act

Part 1
General Provisions

26-19-101 Title.

This chapter is known as the "Medical Benefits Recovery Act."

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-102 Definitions.

As used in this chapter:

(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 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-103 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.

Renumbered and Amended by Chapter 443, 2018 General Session

Part 2
Assignment of Rights

26-19-201 Assignment of rights to benefits.
(1)
(a) 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 and as otherwise provided by law.
(3) 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. That 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.

Renumbered and Amended by Chapter 443, 2018 General Session

Part 3
Insurance Provisions

26-19-301 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, 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 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 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 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-302 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-303 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-304 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-305 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 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.

(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.

Renumbered and Amended by Chapter 443, 2018 General Session

Part 4
General Recovery Provisions

26-19-401 Recovery of medical assistance from third party -- Lien -- Notice -- Action -- Compromise or waiver -- Recipient's right to action protected.

(1)

(a) When 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 that third party.

(b) Any claim arising under Subsection (1)(a) or Section 26-19-201 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by that third party. This lien has priority over all other claims to the proceeds, except claims for attorney fees and costs authorized under Subsection 26-19-403(2)(c)(ii).

(2)

(a) The department shall mail or deliver written notice of its claim or lien to the third party at its 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 its claim or lien in its own name, but that 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 it 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) 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-402 Action by department -- Notice to recipient.
(1)
(a) Within 30 days after commencing an action under Subsection 26-19-401(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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-403 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-404 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(3).
(3) Any amounts assigned to and recoverable by the department pursuant to Sections 26-19-201 and 26-19-401 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 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.

Enacted by Chapter 443, 2018 General Session

26-19-405 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.
(7) A lien imposed under this section is of indefinite duration.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-406 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.

Renumbered and Amended by Chapter 443, 2018 General Session

Part 5
TEFRA Liens

26-19-501 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; and
    (ii) a final notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section 26-19-504; 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.

Enacted by Chapter 443, 2018 General Session

26-19-502 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.

Enacted by Chapter 443, 2018 General Session

26-19-503 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(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(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(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(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; or

(iv) establishes that the real property is exempt from imposition of a TEFRA lien under Subsection 26-19-501(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.

Enacted by Chapter 443, 2018 General Session

26-19-504 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;

(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(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(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.

Enacted by Chapter 443, 2018 General Session

26-19-505 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 may seek agency or judicial review of that decision under Title 63G, Chapter 4, Administrative Procedures Act.

Enacted by Chapter 443, 2018 General Session

26-19-506 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(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; 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(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.

Enacted by Chapter 443, 2018 General Session

26-19-507 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.

Enacted by Chapter 443, 2018 General Session

26-19-508 Contract with another government agency.

If the department contracts with another government agency to recover funds paid for medical assistance under this chapter, that government agency shall be the sole agency that determines whether to impose or remove a TEFRA lien under this part.

Enacted by Chapter 443, 2018 General Session

26-19-509 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.

Enacted by Chapter 443, 2018 General Session

Part 6
Miscellaneous Provisions

26-19-601 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-602 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-603 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.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-604 Department's right to attorney fees and costs.
In any action brought by the department under this chapter in which it prevails, the department shall recover along with the principal sum and interest, a reasonable attorney fee and costs incurred.

Renumbered and Amended by Chapter 443, 2018 General Session

26-19-605 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.

Renumbered and Amended by Chapter 443, 2018 General Session

Chapter 20
Utah False Claims Act

26-20-1 Title.
This chapter is known as the "Utah False Claims Act."

Amended by Chapter 48, 2007 General Session

26-20-2 Definitions.
As used in this chapter:
(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.

Amended by Chapter 48, 2007 General Session

26-20-3 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.

Amended by Chapter 297, 2011 General Session

26-20-4 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.

Repealed and Re-enacted by Chapter 48, 2007 General Session

26-20-5 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.

Amended by Chapter 48, 2007 General Session

26-20-6 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.

Amended by Chapter 297, 2011 General Session

26-20-7 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.

Amended by Chapter 48, 2007 General Session

26-20-8 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.

Amended by Chapter 297, 2011 General Session

26-20-9 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.

Amended by Chapter 48, 2007 General Session

26-20-9.5 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.

Amended by Chapter 297, 2011 General Session

26-20-10 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, 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) 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. 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.

Amended by Chapter 192, 1998 General Session

26-20-11 Presumption based on paid state warrant -- Value of medical benefits -- Repayment of benefits.
(1) In any civil or criminal action brought under this chapter, 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, 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, the repayment of funds or other benefits obtained in violation of the provisions of this chapter does not constitute a defense to, or grounds for dismissal of that action.

Enacted by Chapter 46, 1986 General Session

26-20-12 Violation of other laws.
(1) The provisions of this chapter are:
(a) not exclusive, and the remedies provided for in this chapter 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 or the application of this chapter to any person or circumstance is held unconstitutional:
(a) the remaining provisions of this chapter are not affected; and
(b) the application of this chapter to other persons or circumstances are not affected.

Amended by Chapter 297, 2011 General Session

26-20-13 Medicaid fraud enforcement.
(1) This chapter 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; or
(ii) referring suspected civil violations of this chapter to the attorney general for investigation and prosecution; and
(b) promptly referring suspected criminal violations of this chapter 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; and
(b) exclusive jurisdiction to investigate and prosecute all suspected criminal violations of this chapter.
(4) The department and the attorney general share concurrent civil enforcement authority under this chapter and may enter into an interagency agreement regarding the investigation and prosecution of violations of this chapter in accordance with this section, the requirements of Title XIX of the federal Social Security Act, and applicable federal regulations.
(5) 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. All state government officers and agencies shall cooperate with and assist in any prosecution for violation of this chapter.

Amended by Chapter 48, 2007 General Session

26-20-14 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;
(b) a person is committing, has committed, or is about to commit a violation of this chapter; 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.
(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; 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; 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, 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 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, including presentation before a court.
(12) 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. A complaint under this Subsection (12) shall be filed in district court before the earlier of:
(a) the return date specified in the demand; or
(b) 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 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.

Amended by Chapter 297, 2011 General Session

26-20-15 Limitation of actions -- Civil acts antedating this section -- Civil burden of proof -- Estoppel -- Joint civil liability -- Venue.

(1) An action under this chapter 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 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, 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 which involves the same transaction.
(5) Civil liability under this chapter shall be joint and several for a violation committed by two or more persons.
(6) Any action brought by the state under this chapter shall be brought in district court in Salt Lake County or in any county where the defendant resides or does business.

Enacted by Chapter 48, 2007 General Session

Chapter 21
Health Care Facility Licensing and Inspection Act

Part 1
General Provisions

26-21-1 Title.

This chapter is known as the "Health Care Facility Licensing and Inspection Act."

Amended by Chapter 209, 1997 General Session

26-21-2 Definitions.

As used in this chapter:
(1) "Abortion clinic" means a type I abortion clinic or a type II abortion clinic.
(2) "Activities of daily living" means essential activities including:
  (a) dressing;
  (b) eating;
  (c) grooming;
  (d) bathing;
  (e) toileting;
  (f) ambulation;
  (g) transferring; and
  (h) self-administration of medication.

(3) "Ambulatory surgical facility" means a freestanding facility, which provides surgical services to patients not requiring hospitalization.
(4) "Assistance with activities of daily living" means providing of or arranging for the provision of assistance with activities of daily living.
(5)
(a) "Assisted living facility" means:
(i) a type I assisted living facility, which is a residential facility that provides assistance with activities of daily living and social care to two or more residents who:
(A) require protected living arrangements; and
(B) are capable of achieving mobility sufficient to exit the facility without the assistance of another person; and
(ii) a type II assisted living facility, which is a residential facility with a home-like setting that provides an array of coordinated supportive personal and health care services available 24 hours per day to residents who have been assessed under department rule to need any of these services.
(b) Each resident in a type I or type II assisted living facility shall have a service plan based on the assessment, which may include:
(i) specified services of intermittent nursing care;
(ii) administration of medication; and
(iii) support services promoting residents' independence and self sufficiency.
(6) "Birthing center" means a freestanding facility, receiving maternal clients and providing care during pregnancy, delivery, and immediately after delivery.
(7) "Committee" means the Health Facility Committee created in Section 26-1-7.
(8) "Consumer" means any person not primarily engaged in the provision of health care to individuals or in the administration of facilities or institutions in which such care is provided and who does not hold a fiduciary position, or have a fiduciary interest in any entity involved in the provision of health care, and does not receive, either directly or through his spouse, more than 1/10 of his gross income from any entity or activity relating to health care.
(9) "End stage renal disease facility" means a facility which furnishes staff-assisted kidney dialysis services, self-dialysis services, or home-dialysis services on an outpatient basis.
(10) "Freestanding" means existing independently or physically separated from another health care facility by fire walls and doors and administrated by separate staff with separate records.
(11) "General acute hospital" means a facility which provides diagnostic, therapeutic, and rehabilitative services to both inpatients and outpatients by or under the supervision of physicians.
(12) "Governmental unit" means the state, or any county, municipality, or other political subdivision or any department, division, board, or agency of the state, a county, municipality, or other political subdivision.
(13)
(a) "Health care facility" means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, residential-assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, abortion clinics, facilities owned or operated by health maintenance organizations, end stage renal disease facilities, and any other health care facility which the committee designates by rule.
(b) "Health care facility" does not include the offices of private physicians or dentists, whether for individual or group practice, except that it does include an abortion clinic.
(14) "Health maintenance organization" means an organization, organized under the laws of any state which:

(a) is a qualified health maintenance organization under 42 U.S.C. Sec. 300e-9; or
(b)
(i) provides or otherwise makes available to enrolled participants at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency, and preventive services and out-of-area coverage;
(ii) is compensated, except for copayments, for the provision of the basic health services listed in Subsection (14)(b)(i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health services are provided and which is fixed without regard to the frequency, extent, or kind of health services actually provided; and
(iii) provides physicians' services primarily directly through physicians who are either employees or partners of such organizations, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(15)
(a) "Home health agency" means an agency, organization, or facility or a subdivision of an agency, organization, or facility which employs two or more direct care staff persons who provide licensed nursing services, therapeutic services of physical therapy, speech therapy, occupational therapy, medical social services, or home health aide services on a visiting basis.
(b) "Home health agency" does not mean an individual who provides services under the authority of a private license.

(16) "Hospice" means a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, and supportive care and treatment.

(17) "Nursing care facility" means a health care facility, other than a general acute or specialty hospital, constructed, licensed, and operated to provide patient living accommodations, 24-hour staff availability, and at least two of the following patient services:
(a) a selection of patient care services, under the direction and supervision of a registered nurse, ranging from continuous medical, skilled nursing, psychological, or other professional therapies to intermittent health-related or paraprofessional personal care services;
(b) a structured, supportive social living environment based on a professionally designed and supervised treatment plan, oriented to the individual's habilitation or rehabilitation needs; or
(c) a supervised living environment that provides support, training, or assistance with individual activities of daily living.

(18) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(19) "Resident" means a person 21 years of age or older who:
(a) as a result of physical or mental limitations or age requires or requests services provided in an assisted living facility; and
(b) does not require intensive medical or nursing services as provided in a hospital or nursing care facility.

(20) "Small health care facility" means a four to 16 bed facility that provides licensed health care programs and services to residents.

(21) "Specialty hospital" means a facility which provides specialized diagnostic, therapeutic, or rehabilitative services in the recognized specialty or specialties for which the hospital is licensed.

(22) "Substantial compliance" means in a department survey of a licensee, the department determines there is an absence of deficiencies which would harm the physical health, mental health, safety, or welfare of patients or residents of a licensee.
(23) "Type I abortion clinic" means a facility, including a physician's office, but not including a general acute or specialty hospital, that:
(a) performs abortions, as defined in Section 76-7-301, during the first trimester of pregnancy; and
(b) does not perform abortions, as defined in Section 76-7-301, after the first trimester of pregnancy.
(24) "Type II abortion clinic" means a facility, including a physician's office, but not including a general acute or specialty hospital, that:
(a) performs abortions, as defined in Section 76-7-301, after the first trimester of pregnancy; or
(b) performs abortions, as defined in Section 76-7-301, during the first trimester of pregnancy and after the first trimester of pregnancy.

Amended by Chapter 161, 2011 General Session

26-21-2.1 Services.
(1) General acute hospitals and specialty hospitals shall remain open and be continuously ready to receive patients 24 hours of every day in a year and have an attending medical staff consisting of one or more physicians licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(2) A specialty hospital shall provide on-site all basic services required of a general acute hospital that are needed for the diagnosis, therapy, or rehabilitation offered to or required by patients admitted to or cared for in the facility.
(3)
(a) A home health agency shall provide at least licensed nursing services or therapeutic services directly through the agency employees.
(b) A home health agency may provide additional services itself or under arrangements with another agency, organization, facility, or individual.

Amended by Chapter 209, 1997 General Session

26-21-3 Health Facility Committee -- Members -- Terms -- Organization -- Meetings.
(1) The Health Facility Committee created by Section 26-1-7 consists of 15 members appointed by the governor with the consent of the Senate. The appointed members shall be knowledgeable about health care facilities and issues. The membership of the committee is:
(a) one physician, licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, who is a graduate of a regularly chartered medical school;
(b) one hospital administrator;
(c) one hospital trustee;
(d) one representative of a freestanding ambulatory surgical facility;
(e) one representative of an ambulatory surgical facility that is affiliated with a hospital;
(f) two representatives of the nursing care facility industry;
(g) one registered nurse, licensed to practice under Title 58, Chapter 31b, Nurse Practice Act;
(h) one professional in the field of intellectual disabilities not affiliated with a nursing care facility;
(i) one licensed architect or engineer with expertise in health care facilities;

(j) two representatives of assisted living facilities licensed under this chapter;
(k) two consumers, one of whom has an interest in or expertise in geriatric care; and
(l) one representative from either a home health care provider or a hospice provider.

(2)
(a) Except as required by Subsection (2)(b), members shall be appointed for a term of four years.
(b) Notwithstanding the requirements of Subsection (2)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years.
(c) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term by the governor, giving consideration to recommendations made by the committee, with the consent of the Senate.
(d) A member may not serve more than two consecutive full terms or 10 consecutive years, whichever is less. However, a member may continue to serve as a member until he is replaced.
(e) The committee shall annually elect from its membership a chair and vice chair.
(f) The committee shall meet at least quarterly, or more frequently as determined by the chair or five members of the committee.
(g) Eight members constitute a quorum. A vote of the majority of the members present constitutes action of the committee.

Amended by Chapter 366, 2011 General Session

26-21-4 Per diem and travel expenses of committee members.

A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
(1) Section 63A-3-106;
(2) Section 63A-3-107; and
(3) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 286, 2010 General Session

26-21-5 Duties of committee.

The committee shall:
(1) with the concurrence of the department, make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:
(a) for the licensing of health-care facilities; and
(b) requiring the submission of architectural plans and specifications for any proposed new health-care facility or renovation to the department for review;
(2) approve the information for applications for licensure pursuant to Section 26-21-9;
(3) advise the department as requested concerning the interpretation and enforcement of the rules established under this chapter; and
(4) advise, consult, cooperate with, and provide technical assistance to other agencies of the state and federal government, and other states and affected groups or persons in carrying out the purposes of this chapter.

Amended by Chapter 74, 2016 General Session

26-21-6 Duties of department.

(1) The department shall:
  (a) enforce rules established pursuant to this chapter;
  (b) authorize an agent of the department to conduct inspections of health care facilities pursuant to this chapter;
  (c) collect information authorized by the committee that may be necessary to ensure that adequate health care facilities are available to the public;
  (d) collect and credit fees for licenses as free revenue;
  (e) collect and credit fees for conducting plan reviews as dedicated credits;
  (f)
    (i) collect and credit fees for conducting clearance under Chapter 21, Part 2, Clearance for Direct Patient Access; and
    (ii) beginning July 1, 2012:
      (A) up to $105,000 of the fees collected under Subsection (1)(f)(i) are dedicated credits; and
      (B) the fees collected for background checks under Subsection 26-21-204(6) and Section 26-21-205 shall be transferred to the Department of Public Safety to reimburse the Department of Public Safety for its costs in conducting the federal background checks;
  (g) designate an executive secretary from within the department to assist the committee in carrying out its powers and responsibilities;
  (h) establish reasonable standards for criminal background checks by public and private entities;
  (i) recognize those public and private entities that meet the standards established pursuant to Subsection (1)(h); and
  (j) provide necessary administrative and staff support to the committee.
(2) The department may:
  (a) exercise all incidental powers necessary to carry out the purposes of this chapter;
  (b) review architectural plans and specifications of proposed health care facilities or renovations of health care facilities to ensure that the plans and specifications conform to rules established by the committee; and
  (c) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules as necessary to implement the provisions of this chapter.

Amended by Chapter 74, 2016 General Session

26-21-6.5 Licensing of an abortion clinic -- Rulemaking authority -- Fee.

(1) A type I abortion clinic may not operate in the state without a license issued by the department to operate a type I abortion clinic.
(2) A type II abortion clinic may not operate in the state without a license issued by the department to operate a type II abortion clinic.
(3) The department shall make rules establishing minimum health, safety, sanitary, and recordkeeping requirements for:
  (a) a type I abortion clinic; and
  (b) a type II abortion clinic.
(4) To receive and maintain a license described in this section, an abortion clinic shall:
  (a) apply for a license on a form prescribed by the department;
  (b) satisfy and maintain the minimum health, safety, sanitary, and recordkeeping requirements established under Subsection (3) that relate to the type of abortion clinic licensed;
  (c) comply with the recordkeeping and reporting requirements of Section 76-7-313;
  (d) comply with the requirements of Title 76, Chapter 7, Part 3, Abortion;

(e) pay the annual licensing fee; and
(f) cooperate with inspections conducted by the department.
(5) The department shall, at least twice per year, inspect each abortion clinic in the state to ensure that the abortion clinic is complying with all statutory and licensing requirements relating to the abortion clinic. At least one of the inspections shall be made without providing notice to the abortion clinic.
(6) The department shall charge an annual license fee, set by the department in accordance with the procedures described in Section 63J-1-504, to an abortion clinic in an amount that will pay for the cost of the licensing requirements described in this section and the cost of inspecting abortion clinics.
(7) The department shall deposit the licensing fees described in this section in the General Fund as a dedicated credit to be used solely to pay for the cost of the licensing requirements described in this section and the cost of inspecting abortion clinics.

Amended by Chapter 282, 2018 General Session

26-21-7 Exempt facilities.

This chapter does not apply to:
(1) a dispensary or first aid facility maintained by any commercial or industrial plant, educational institution, or convent;
(2) a health care facility owned or operated by an agency of the United States;
(3) the office of a physician, physician assistant, or dentist whether it is an individual or group practice, except that it does apply to an abortion clinic;
(4) a health care facility established or operated by any recognized church or denomination for the practice of religious tenets administered by mental or spiritual means without the use of drugs, whether gratuitously or for compensation, if it complies with statutes and rules on environmental protection and life safety;
(5) any health care facility owned or operated by the Department of Corrections, created in Section 64-13-2; and
(6) a residential facility providing 24-hour care:
(a) that does not employ direct care staff;
(b) in which the residents of the facility contract with a licensed hospice agency to receive end-of-life medical care; and
(c) that meets other requirements for an exemption as designated by administrative rule.

Amended by Chapter 349, 2019 General Session

26-21-8 License required -- Not assignable or transferable -- Posting -- Expiration and renewal -- Time for compliance by operating facilities.

(1)
(a) A person or governmental unit acting severally or jointly with any other person or governmental unit, may not establish, conduct, or maintain a health care facility in this state without receiving a license from the department as provided by this chapter and the rules adopted pursuant to this chapter .
(b) This Subsection (1) does not apply to facilities that are exempt under Section 26-21-7.
(2) A license issued under this chapter is not assignable or transferable.
(3) The current license shall at all times be posted in each health care facility in a place readily visible and accessible to the public.

(4)
(a) The department may issue a license for a period of time not to exceed 12 months from the date of issuance for an abortion clinic and not to exceed 24 months from the date of issuance for other health care facilities that meet the provisions of this chapter and department rules adopted pursuant to this chapter.
(b) Each license expires at midnight on the day designated on the license as the expiration date, unless previously revoked by the department.
(c) The license shall be renewed upon completion of the application requirements, unless the department finds the health care facility has not complied with the provisions of this chapter or the rules adopted pursuant to this chapter.
(5) A license may be issued under this section only for the operation of a specific facility at a specific site by a specific person.
(6) Any health care facility in operation at the time of adoption of any applicable rules as provided under this chapter shall be given a reasonable time for compliance as determined by the committee.

Amended by Chapter 74, 2016 General Session

26-21-9 Application for license -- Information required -- Public records.
(1) An application for license shall be made to the department in a form prescribed by the department. The application and other documentation requested by the department as part of the application process shall require such information as the committee determines necessary to ensure compliance with established rules.
(2) Information received by the department in reports and inspections shall be public records, except the information may not be disclosed if it directly or indirectly identifies any individual other than the owner or operator of a health facility (unless disclosure is required by law) or if its disclosure would otherwise constitute an unwarranted invasion of personal privacy.
(3) Information received by the department from a health care facility, pertaining to that facility's accreditation by a voluntary accrediting organization, shall be private data except for a summary prepared by the department related to licensure standards.

Amended by Chapter 297, 2011 General Session

26-21-11 Violations -- Denial or revocation of license -- Restricting or prohibiting new admissions -- Monitor.
If the department finds a violation of this chapter or any rules adopted pursuant to this chapter the department may take one or more of the following actions:
(1) serve a written statement of violation requiring corrective action, which shall include time frames for correction of all violations;
(2) deny or revoke a license if it finds:
(a) there has been a failure to comply with the rules established pursuant to this chapter;
(b) evidence of aiding, abetting, or permitting the commission of any illegal act; or
(c) conduct adverse to the public health, morals, welfare, and safety of the people of the state;
(3) restrict or prohibit new admissions to a health care facility or revoke the license of a health care facility for:
(a) violation of any rule adopted under this chapter; or
(b) permitting, aiding, or abetting the commission of any illegal act in the health care facility;

(4) place a department representative as a monitor in the facility until corrective action is completed;
(5) assess to the facility the cost incurred by the department in placing a monitor;
(6) assess an administrative penalty as allowed by Subsection 26-23-6(1)(a); or
(7) issue a cease and desist order to the facility.

Amended by Chapter 209, 1997 General Session

26-21-11.1 Failure to follow certain health care claims practices -- Penalties.
(1) The department may assess a fine of up to $500 per violation against a health care facility that violates Section 31A-26-313.
(2) The department shall waive the fine described in Subsection (1) if:
(a) the health care facility demonstrates to the department that the health care facility mitigated and reversed any damage to the insured caused by the health care facility or third party's violation; or
(b) the insured does not pay the full amount due on the bill that is the subject of the violation, including any interest, fees, costs, and expenses, within 120 days after the day on which the health care facility or third party makes a report to a credit bureau or takes an action in violation of Section 31A-26-313.

Amended by Chapter 203, 2018 General Session

26-21-12 Issuance of new license after revocation -- Restoration.
(1) If a license is revoked, the department may issue a new license only after it determines by inspection that the facility has corrected the conditions that were the basis of revocation and that the facility complies with all provisions of this chapter and applicable rules.
(2) If the department does not renew a license because of noncompliance with the provisions of this chapter or the rules adopted under this chapter, the department may issue a new license only after the facility complies with all renewal requirements and the department determines that the interests of the public will not be jeopardized.

Amended by Chapter 209, 1997 General Session

26-21-13 License issued to facility in compliance or substantial compliance with chapter and rules.
(1) The department shall issue a standard license for a health care facility which is found to be in compliance with the provisions of this chapter and with all applicable rules adopted by the committee.
(2) The department may issue a provisional or conditional license for a health care facility which is in substantial compliance if the interests of the public will not be jeopardized.

Amended by Chapter 114, 1990 General Session

26-21-13.5 Intermediate care facilities for people with an intellectual disability -- Licensing.
(1)
(a) It is the Legislature's intent that a person with a developmental disability be provided with an environment and surrounding that, as closely as possible, resembles small community-based,

homelike settings, to allow those persons to have the opportunity, to the maximum extent feasible, to exercise their full rights and responsibilities as citizens.

(b) It is the Legislature's purpose, in enacting this section, to provide assistance and opportunities to enable a person with a developmental disability to achieve the person's maximum potential through increased independence, productivity, and integration into the community.

(2) After July 1, 1990, the department may only license intermediate care beds for people with an intellectual disability in small health care facilities.

(3) The department may define by rule "small health care facility" for purposes of licensure under this section and adopt rules necessary to carry out the requirements and purposes of this section.

(4) This section does not apply to the renewal of a license or the licensure to a new owner of any facility that was licensed on or before July 1, 1990, and that licensure has been maintained without interruption.

Amended by Chapter 366, 2011 General Session

26-21-13.6 Rural hospital -- Optional service designation.

(1) The Legislature finds that:

(a) the rural citizens of this state need access to hospitals and primary care clinics;

(b) financial stability of remote-rural hospitals and their integration into remote-rural delivery networks is critical to ensure the continued viability of remote-rural health care; and

(c) administrative simplicity is essential for providing large benefits to small-scale remote-rural providers who have limited time and resources.

(2) After July 1, 1995, the department may grant variances to remote-rural acute care hospitals for specific services currently required for licensure under general hospital standards established by department rule.

(3) For purposes of this section, "remote-rural hospitals" are hospitals that are in a county with less than 20 people per square mile.

Enacted by Chapter 321, 1995 General Session

26-21-14 Closing facility -- Appeal.

(1) If the department finds a condition in any licensed health care facility that is a clear hazard to the public health, the department may immediately order that facility closed and may prevent the entrance of any resident or patient onto the premises of that facility until the condition is eliminated.

(2) Parties aggrieved by the actions of the department under this section may obtain an adjudicative proceeding and judicial review.

Amended by Chapter 114, 1990 General Session

26-21-15 Action by department for injunction.

Notwithstanding the existence of any other remedy, the department may, in the manner provided by law, upon the advice of the attorney general, who shall represent the department in the proceedings, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of a health care facility which is in violation of this chapter or rules adopted by the committee.

Amended by Chapter 114, 1990 General Session

26-21-16 Operating facility in violation of chapter a misdemeanor.

In addition to the penalties in Section 26-23-6, any person owning, establishing, conducting, maintaining, managing, or operating a health care facility in violation of this chapter is guilty of a class A misdemeanor.

Amended by Chapter 347, 2009 General Session

26-21-17 Department agency of state to contract for certification of facilities under Social Security Act.

The department is the sole agency of the state authorized to enter into a contract with the United States government for the certification of health care facilities under Title XVIII and Title XIX of the Social Security Act, and any amendments thereto.

Amended by Chapter 114, 1990 General Session

26-21-19 Life and Health Insurance Guaranty Association Act not amended.

The provisions of this chapter do not amend, affect, or alter the provisions of Title 31A, Chapter 28, Guaranty Associations.

Amended by Chapter 242, 1985 General Session

26-21-20 Requirement for hospitals to provide statements of itemized charges to patients.

(1) For purposes of this section, "hospital" includes:
  (a) an ambulatory surgical facility;
  (b) a general acute hospital; and
  (c) a specialty hospital.
(2) A hospital shall provide a statement of itemized charges to any patient receiving medical care or other services from that hospital.
(3)
  (a) The statement shall be provided to the patient or the patient's personal representative or agent at the hospital's expense, personally, by mail, or by verifiable electronic delivery after the hospital receives an explanation of benefits from a third party payer which indicates the patient's remaining responsibility for the hospital charges.
  (b) If the statement is not provided to a third party, it shall be provided to the patient as soon as possible and practicable.
(4) The statement required by this section:
  (a) shall itemize each of the charges actually provided by the hospital to the patient;
  (b)
    (i) shall include the words in bold "THIS IS THE BALANCE DUE AFTER PAYMENT FROM YOUR HEALTH INSURER"; or
    (ii) shall include other appropriate language if the statement is sent to the patient under Subsection (3)(b); and
  (c) may not include charges of physicians who bill separately.
(5) The requirements of this section do not apply to patients who receive services from a hospital under Title XIX of the Social Security Act.

(6) Nothing in this section prohibits a hospital from sending an itemized billing statement to a patient before the hospital has received an explanation of benefits from an insurer. If a hospital provides a statement of itemized charges to a patient prior to receiving the explanation of benefits from an insurer, the itemized statement shall be marked in bold: "DUPLICATE: DO NOT PAY" or other appropriate language.

Amended by Chapter 11, 2009 General Session

26-21-21 Authentication of medical records.

Any entry in a medical record compiled or maintained by a health care facility may be authenticated by identifying the author of the entry by:
(1) a signature including first initial, last name, and discipline; or
(2) the use of a computer identification process unique to the author that definitively identifies the author.

Enacted by Chapter 31, 1992 General Session

26-21-22 Reporting of disciplinary information -- Immunity from liability.

A health care facility licensed under this chapter which reports disciplinary information on a licensed nurse to the Division of Occupational and Professional Licensing within the Department of Commerce as required by Section 58-31b-702 is entitled to the immunity from liability provided by that section.

Enacted by Chapter 288, 1998 General Session

26-21-23 Licensing of a new nursing care facility -- Approval for a licensed bed in an existing nursing care facility -- Fine for excess Medicare inpatient revenue.

(1) Notwithstanding Section 26-21-2, as used in this section:
(a) "Medicaid" means the Medicaid program, as that term is defined in Section 26-18-2.
(b) "Medicaid certification" means the same as that term is defined in Section 26-18-501.
(c) "Nursing care facility" and "small health care facility":
(i) mean the following facilities licensed by the department under this chapter:
(A) a skilled nursing facility;
(B) an intermediate care facility; or
(C) a small health care facility with four to 16 beds functioning as a skilled nursing facility; and
(ii) do not mean:
(A) an intermediate care facility for the intellectually disabled;
(B) a critical access hospital that meets the criteria of 42 U.S.C. 1395i-4(c)(2) (1998);
(C) a small health care facility that is hospital based; or
(D) a small health care facility other than a skilled nursing care facility with no more than 16 beds.
(d) "Rural county" means the same as that term is defined in Section 26-18-501.
(2) Except as provided in Subsection (6) and Section 26-21-28, a new nursing care facility shall be approved for a health facility license only if:
(a) under the provisions of Section 26-18-503 the facility's nursing care facility program has received Medicaid certification or will receive Medicaid certification for each bed in the facility;

(b) the facility's nursing care facility program has received or will receive approval for Medicaid certification under Subsection 26-18-503(5), if the facility is located in a rural county; or

(c)

(i) the applicant submits to the department the information described in Subsection (3); and

(ii) based on that information, and in accordance with Subsection (4), the department determines that approval of the license best meets the needs of the current and future patients of nursing care facilities within the area impacted by the new facility.

(3) A new nursing care facility seeking licensure under Subsection (2) shall submit to the department the following information:

(a) proof of the following as reasonable evidence that bed capacity provided by nursing care facilities within the county or group of counties that would be impacted by the facility is insufficient:

(i) nursing care facility occupancy within the county or group of counties:

(A) has been at least 75% during each of the past two years for all existing facilities combined; and

(B) is projected to be at least 75% for all nursing care facilities combined that have been approved for licensure but are not yet operational;

(ii) there is no other nursing care facility within a 35-mile radius of the new nursing care facility seeking licensure under Subsection (2); and

(b) a feasibility study that:

(i) shows the facility's annual Medicare inpatient revenue, including Medicare Advantage revenue, will not exceed 49% of the facility's annual total revenue during each of the first three years of operation;

(ii) shows the facility will be financially viable if the annual occupancy rate is at least 88%;

(iii) shows the facility will be able to achieve financial viability;

(iv) shows the facility will not:

(A) have an adverse impact on existing or proposed nursing care facilities within the county or group of counties that would be impacted by the facility; or

(B) be within a three-mile radius of an existing nursing care facility or a new nursing care facility that has been approved for licensure but is not yet operational;

(v) is based on reasonable and verifiable demographic and economic assumptions;

(vi) is based on data consistent with department or other publicly available data; and

(vii) is based on existing sources of revenue.

(4) When determining under Subsection (2)(c) whether approval of a license for a new nursing care facility best meets the needs of the current and future patients of nursing care facilities within the area impacted by the new facility, the department shall consider:

(a) whether the county or group of counties that would be impacted by the facility is underserved by specialized or unique services that would be provided by the facility; and

(b) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of current and future nursing care facility patients within the impacted area.

(5) The department may approve the addition of a licensed bed in an existing nursing care facility only if:

(a) each time the facility seeks approval for the addition of a licensed bed, the facility satisfies each requirement for licensure of a new nursing care facility in Subsections (2)(c), (3), and (4); or

(b) the bed has been approved for Medicaid certification under Section 26-18-503 or 26-18-505.

(6) Subsection (2) does not apply to a nursing care facility that:

(a) has, by the effective date of this act, submitted to the department schematic drawings, and paid applicable fees, for a particular site or a site within a three-mile radius of that site;
(b) before July 1, 2016:
(i) filed an application with the department for licensure under this section and paid all related fees due to the department; and
(ii) submitted to the department architectural plans and specifications, as defined by the department by administrative rule, for the facility;
(c) applies for a license within three years of closing for renovation;
(d) replaces a nursing care facility that:
(i) closed within the past three years; or
(ii) is located within five miles of the facility;
(e) is undergoing a change of ownership, even if a government entity designates the facility as a new nursing care facility; or
(f) is a state-owned veterans home, regardless of who operates the home.
(7)
(a) For each year the annual Medicare inpatient revenue, including Medicare Advantage revenue, of a nursing care facility approved for a health facility license under Subsection (2)(c) exceeds 49% of the facility's total revenue for the year, the facility shall be subject to a fine of $50,000, payable to the department.
(b) A nursing care facility approved for a health facility license under Subsection (2)(c) shall submit to the department the information necessary for the department to annually determine whether the facility is subject to the fine in Subsection (7)(a).
(c) The department:
(i) shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying the information a nursing care facility shall submit to the department under Subsection (7)(b);
(ii) shall annually determine whether a facility is subject to the fine in Subsection (7)(a);
(iii) may take one or more of the actions in Section 26-21-11 or 26-23-6 against a facility for nonpayment of a fine due under Subsection (7)(a); and
(iv) shall deposit fines paid to the department under Subsection (7)(a) into the Nursing Care Facilities Provider Assessment Fund, created by Section 26-35a-106.

Amended by Chapter 443, 2017 General Session

26-21-24 Prohibition against bed banking by nursing care facilities for Medicaid reimbursement.
(1) For purposes of this section:
(a) "bed banking" means the designation of a nursing care facility bed as not part of the facility's operational bed capacity; and
(b) "nursing care facility" is as defined in Subsection 26-21-23(1).
(2) Beginning July 1, 2008, the department shall, for purposes of Medicaid reimbursement under Chapter 18, Part 1, Medical Assistance Programs, prohibit the banking of nursing care facility beds.

Enacted by Chapter 347, 2008 General Session

26-21-25 Patient identity protection.
(1) As used in this section:

(a) "EMTALA" means the federal Emergency Medical Treatment and Active Labor Act.
(b) "Health professional office" means:
(i) a physician's office; or
(ii) a dental office.
(c) "Medical facility" means:
(i) a general acute hospital;
(ii) a specialty hospital;
(iii) a home health agency;
(iv) a hospice;
(v) a nursing care facility;
(vi) a residential-assisted living facility;
(vii) a birthing center;
(viii) an ambulatory surgical facility;
(ix) a small health care facility;
(x) an abortion clinic;
(xi) a facility owned or operated by a health maintenance organization;
(xii) an end stage renal disease facility;
(xiii) a health care clinic; or
(xiv) any other health care facility that the committee designates by rule.
(2)
(a) In order to discourage identity theft and health insurance fraud, and to reduce the risk of medical errors caused by incorrect medical records, a medical facility or a health professional office shall request identification from an individual prior to providing in-patient or out-patient services to the individual.
(b) If the individual who will receive services from the medical facility or a health professional office lacks the legal capacity to consent to treatment, the medical facility or a health professional office shall request identification:
(i) for the individual who lacks the legal capacity to consent to treatment; and
(ii) from the individual who consents to treatment on behalf of the individual described in Subsection (2)(b)(i).
(3) A medical facility or a health professional office:
(a) that is subject to EMTALA:
(i) may not refuse services to an individual on the basis that the individual did not provide identification when requested; and
(ii) shall post notice in its emergency department that informs a patient of the patient's right to treatment for an emergency medical condition under EMTALA;
(b) may not be penalized for failing to ask for identification;
(c) is not subject to a private right of action for failing to ask for identification; and
(d) may document or confirm patient identity by:
(i) photograph;
(ii) fingerprinting;
(iii) palm scan; or
(iv) other reasonable means.
(4) The identification described in this section:
(a) is intended to be used for medical records purposes only; and
(b) shall be kept in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Amended by Chapter 218, 2010 General Session

26-21-26 General acute hospital to report prescribed controlled substance poisoning or overdose.

(1) If a person who is 12 years of age or older is admitted to a general acute hospital for poisoning or overdose involving a prescribed controlled substance, the general acute hospital shall, within three business days after the day on which the person is admitted, send a written report to the Division of Occupational and Professional Licensing, created in Section 58-1-103, that includes:
  (a) the patient's name and date of birth;
  (b) each drug or other substance found in the person's system that may have contributed to the poisoning or overdose, if known;
  (c) the name of each person who the general acute hospital has reason to believe may have prescribed a controlled substance described in Subsection (1)(b) to the person, if known; and
  (d) the name of the hospital and the date of admission.
(2) Nothing in this section may be construed as creating a new cause of action.

Amended by Chapter 99, 2016 General Session

26-21-27 Consumer access to health care facility charges.

Beginning January 1, 2011, a health care facility licensed under this chapter shall, when requested by a consumer:
(1) make a list of prices charged by the facility available for the consumer that includes the facility's:
  (a) in-patient procedures;
  (b) out-patient procedures;
  (c) the 50 most commonly prescribed drugs in the facility;
  (d) imaging services; and
  (e) implants; and
(2) provide the consumer with information regarding any discounts the facility provides for:
  (a) charges for services not covered by insurance; or
  (b) prompt payment of billed charges.

Enacted by Chapter 68, 2010 General Session

26-21-28 Pilot program for managed care model with a small health care facility operating as a skilled nursing facility.

(1) Notwithstanding the requirement for Medicaid certification under Chapter 18, Part 5, Long Term Care Facility - Medicaid Certification, and Section 26-21-23, a small health care facility with four to 16 beds, functioning as a skilled nursing facility, may be approved for licensing by the department as a pilot program in accordance with this section, and without obtaining Medicaid certification for the beds in the facility.
(2)
  (a) The department shall establish one pilot program with a facility that meets the qualifications under Subsection (3). The purpose of the pilot program is to study the impact of an integrated managed care model on cost and quality of care involving pre- and post-surgical services offered by a small health care facility operating as a skilled nursing facility.
  (b) The small health care facility that is operating as a skilled nursing facility and is participating in the pilot program, shall, on or before November 30, 2020, issue a report to the Legislative

Health and Human Services Interim Committee on patient outcomes and cost of care associated with the pilot program.

(3) A small health care facility with four to 16 beds that functions as a skilled nursing facility may apply for a license under the pilot program if the facility will:

(a) be located in:

(i) a county of the second class that has at least 1,800 square miles within the county; and

(ii) a city of the fifth class; and

(b) limit a patient's stay in the facility to no more than 10 days.

Enacted by Chapter 357, 2016 General Session

26-21-29 Birthing centers -- Regulatory restrictions.

(1) For purposes of this section:

(a) "Certified nurse midwife" means an individual who is licensed under Title 58, Chapter 44a, Nurse Midwife Practice Act.

(b) "Direct-entry midwife" means an individual who is licensed under Title 58, Chapter 77, Direct-Entry Midwife Act.

(c) "Licensed maternity care practitioner" includes:

(i) a physician;

(ii) a certified nurse midwife;

(iii) a direct entry midwife;

(iv) a naturopathic physician; and

(v) other individuals who are licensed under Title 58, Occupations and Professions and whose scope of practice includes midwifery or obstetric care.

(d) "Naturopathic physician" means an individual who is licensed under Title 58, Chapter 71, Naturopathic Physician Practice Act.

(e) "Physician" means an individual who is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(2) The Health Facility Committee and the department may not require a birthing center or a licensed maternity care practitioner who practices at a birthing center to:

(a) maintain admitting privileges at a general acute hospital;

(b) maintain a written transfer agreement with one or more general acute hospitals;

(c) maintain a collaborative practice agreement with a physician; or

(d) have a physician or certified nurse midwife present at each birth when another licensed maternity care practitioner is present at the birth and remains until the maternal patient and newborn are stable postpartum.

(3) The Health Facility Committee and the department shall:

(a) permit all types of licensed maternity care practitioners to practice in a birthing center; and

(b) except as provided in Subsection (2)(b), require a birthing center to have a written plan for the transfer of a patient to a hospital in accordance with Subsection (4).

(4) A transfer plan under Subsection (3)(b) shall:

(a) be signed by the patient; and

(b) indicate that the plan is not an agreement with a hospital.

(5) If a birthing center transfers a patient to a licensed maternity care practitioner or facility, the responsibility of the licensed maternity care practitioner or facility, for the patient:

(a) does not begin until the patient is physically within the care of the licensed maternity care practitioner or facility;

(b) is limited to the examination and care provided after the patient is transferred to the licensed maternity care practitioner or facility; and
(c) does not include responsibility or accountability for the patient's decision to pursue an out-of-hospital birth and the services of a birthing center.
(6)
(a) Except as provided in Subsection (6)(c), a licensed maternity care practitioner who is not practicing at a birthing center may, upon receiving a briefing from a member of a birthing center's clinical staff, issue a medical order for the birthing center's patient without assuming liability for the care of the patient for whom the order was issued.
(b) Regardless of the advice given or order issued under Subsection (6)(a), the responsibility and liability for caring for the patient is that of the birthing center and the birthing center's clinical staff.
(c) The licensed maternity care practitioner giving the order under Subsection (6)(a) is responsible and liable only for the appropriateness of the order, based on the briefing received under Subsection (6)(a).
(7) The department shall hold a public hearing under Subsection 63G-3-302(2)(a) for a proposed administrative rule, and amendment to a rule, or repeal of a rule, that relates to birthing centers.

Enacted by Chapter 73, 2016 General Session

26-21-30 Disposal of controlled substances at nursing care facilities.
(1) As used in this section:
(a) "Controlled substance" means the same as that term is defined in Section 58-37-2.
(b)
(i) "Irretrievable" means a state in which the physical or chemical condition of a controlled substance is permanently altered through irreversible means so that the controlled substance is unavailable and unusable for all practical purposes.
(ii) A controlled substance is irretrievable if the controlled substance is non-retrievable as that term is defined in 21 C.F.R. Sec. 1300.05.
(2) A nursing care facility that is in lawful possession of a controlled substance in the nursing care facility's inventory that desires to dispose of the controlled substance shall dispose of the controlled substance in a manner that:
(a) renders the controlled substance irretrievable; and
(b) complies with all applicable federal and state requirements for the disposal of a controlled substance.
(3) A nursing care facility shall:
(a) develop a written plan for the disposal of a controlled substance in accordance with this section; and
(b) make the plan described in Subsection (3)(a) available to the department and the committee for inspection.

Enacted by Chapter 157, 2018 General Session

26-21-31 Prohibition on certain age-based physician testing.
A health care facility may not require for purposes of employment, privileges, or reimbursement, that a physician, as defined in Section 58-67-102, take a cognitive test when the physician reaches a specified age, unless the test reflects the standards described in Subsections 58-67-302(5)(b)(i) through (x).

Amended by Chapter 445, 2019 General Session

26-21-32 Notification of air ambulance policies and charges.

(1) For any patient who is in need of air medical transport provider services, a health care facility shall:
  (a) provide the patient or the patient's representative with the information described in Subsection 26-8a-107(7)(a) before contacting an air medical transport provider; and
  (b) if multiple air medical transport providers are capable of providing the patient with services, provide the patient or the patient's representative with an opportunity to choose the air medical transport provider.
(2) Subsection (1) does not apply if the patient:
  (a) is unconscious and the patient's representative is not physically present with the patient; or
  (b) is unable, due to a medical condition, to make an informed decision about the choice of an air medical transport provider, and the patient's representative is not physically present with the patient.

Enacted by Chapter 262, 2019 General Session

26-21-100 Reserved.

Reserved

Enacted by Chapter 328, 2012 General Session

Part 2
Clearance for Direct Patient Access

26-21-201 Definitions.

As used in this part:
(1) "Clearance" means approval by the department under Section 26-21-203 for an individual to have direct patient access.
(2) "Covered body" means a covered provider, covered contractor, or covered employer.
(3) "Covered contractor" means a person that supplies covered individuals, by contract, to a covered employer or covered provider.
(4) "Covered employer" means an individual who:
  (a) engages a covered individual to provide services in a private residence to:
    (i) an aged individual, as defined by department rule; or
    (ii) a disabled individual, as defined by department rule;
  (b) is not a covered provider; and
  (c) is not a licensed health care facility within the state.
(5) "Covered individual":
  (a) means an individual:
    (i) whom a covered body engages; and
    (ii) who may have direct patient access;
  (b) includes:
    (i) a nursing assistant, as defined by department rule;

(ii) a personal care aide, as defined by department rule;
(iii) an individual licensed to engage in the practice of nursing under Title 58, Chapter 31b, Nurse Practice Act;
(iv) a provider of medical, therapeutic, or social services, including a provider of laboratory and radiology services;
(v) an executive;
(vi) administrative staff, including a manager or other administrator;
(vii) dietary and food service staff;
(viii) housekeeping and maintenance staff; and
(ix) any other individual, as defined by department rule, who has direct patient access; and
(c) does not include a student, as defined by department rule, directly supervised by a member of the staff of the covered body or the student's instructor.
(6) "Covered provider" means:
(a) an end stage renal disease facility;
(b) a long-term care hospital;
(c) a nursing care facility;
(d) a small health care facility;
(e) an assisted living facility;
(f) a hospice;
(g) a home health agency; or
(h) a personal care agency.
(7) "Direct patient access" means for an individual to be in a position where the individual could, in relation to a patient or resident of the covered body who engages the individual:
(a) cause physical or mental harm;
(b) commit theft; or
(c) view medical or financial records.
(8) "Engage" means to obtain one's services:
(a) by employment;
(b) by contract;
(c) as a volunteer; or
(d) by other arrangement.
(9) "Long-term care hospital":
(a) means a hospital that is certified to provide long-term care services under the provisions of 42 U.S.C. Sec. 1395tt; and
(b) does not include a critical access hospital, designated under 42 U.S.C. Sec. 1395i-4(c)(2).
(10) "Patient" means an individual who receives health care services from one of the following covered providers:
(a) an end stage renal disease facility;
(b) a long-term care hospital;
(c) a hospice;
(d) a home health agency; or
(e) a personal care agency.
(11) "Personal care agency" means a health care facility defined by department rule.
(12) "Resident" means an individual who receives health care services from one of the following covered providers:
(a) a nursing care facility;
(b) a small health care facility;
(c) an assisted living facility; or

(d) a hospice that provides living quarters as part of its services.
(13) "Residential setting" means a place provided by a covered provider:
(a) for residents to live as part of the services provided by the covered provider; and
(b) where an individual who is not a resident also lives.
(14) "Volunteer" means an individual, as defined by department rule, who provides services without pay or other compensation.

Enacted by Chapter 328, 2012 General Session

26-21-202 Clearance required.
(1) A covered provider may engage a covered individual only if the individual has clearance.
(2) A covered contractor may supply a covered individual to a covered employer or covered provider only if the individual has clearance.
(3) A covered employer may engage a covered individual who does not have clearance.
(4)
(a) Notwithstanding Subsections (1) and (2), if a covered individual does not have clearance, a covered provider may engage the individual or a covered contractor may supply the individual to a covered provider or covered employer:
(i) under circumstances specified by department rule; and
(ii) only while an application for clearance for the individual is pending.
(b) For purposes of Subsection (4)(a), an application is pending if the following have been submitted to the department for the individual:
(i) an application for clearance;
(ii) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
(iii) any fees established by the department under Subsection 26-21-204(9).

Enacted by Chapter 328, 2012 General Session

26-21-203 Department authorized to grant, deny, or revoke clearance -- Department may limit direct patient access.
(1) As provided in Section 26-21-204, the department may grant, deny, or revoke clearance for an individual, including a covered individual.
(2) The department may limit the circumstances under which a covered individual granted clearance may have direct patient access, based on the relationship the factors under Subsection 26-21-204(4)(a) and other mitigating factors may have to patient and resident protection.

Enacted by Chapter 328, 2012 General Session

26-21-204 Clearance.
(1) The department shall determine whether to grant clearance for each applicant for whom it receives:
(a) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
(b) any fees established by the department under Subsection 26-21-204(9).
(2) The department shall establish a procedure for obtaining and evaluating relevant information concerning covered individuals, including fingerprinting the applicant and submitting the prints

to the Criminal Investigations and Technical Services Division of the Department of Public Safety for checking against applicable state, regional, and national criminal records files.

(3) The department may review the following sources to determine whether an individual should be granted or retain clearance, which may include:

(a) Department of Public Safety arrest, conviction, and disposition records described in Title 53, Chapter 10, Criminal Investigations and Technical Services Act, including information in state, regional, and national records files;

(b) juvenile court arrest, adjudication, and disposition records, as allowed under Section 78A-6-209;

(c) federal criminal background databases available to the state;

(d) the Department of Human Services' Division of Child and Family Services Licensing Information System described in Section 62A-4a-1006;

(e) child abuse or neglect findings described in Section 78A-6-323;

(f) the Department of Human Services' Division of Aging and Adult Services vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1;

(g) registries of nurse aids described in 42 C.F.R. Sec. 483.156;

(h) licensing and certification records of individuals licensed or certified by the Division of Occupational and Professional Licensing under Title 58, Occupations and Professions; and

(i) the List of Excluded Individuals and Entities database maintained by the United States Department of Health and Human Services' Office of Inspector General.

(4) The department shall adopt rules that:

(a) specify the criteria the department will use to determine whether an individual is granted or retains clearance:

(i) based on an initial evaluation and ongoing review of information under Subsection (3); and

(ii) including consideration of the relationship the following may have to patient and resident protection:

(A) warrants for arrest;

(B) arrests;

(C) convictions, including pleas in abeyance;

(D) pending diversion agreements;

(E) adjudications by a juvenile court of committing an act that if committed by an adult would be a felony or misdemeanor, if the individual is over 28 years of age and has been convicted, has pleaded no contest, or is subject to a plea in abeyance or diversion agreement for a felony or misdemeanor, or the individual is under 28 years of age; and

(F) any other findings under Subsection (3); and

(b) specify the personal identification information that must be submitted by an individual or covered body with an application for clearance, including:

(i) the applicant's Social Security number; and

(ii) fingerprints.

(5) For purposes of Subsection (4)(a), the department shall classify a crime committed in another state according to the closest matching crime under Utah law, regardless of how the crime is classified in the state where the crime was committed.

(6) The Department of Public Safety, the Administrative Office of the Courts, the Department of Human Services, the Division of Occupational and Professional Licensing, and any other state agency or political subdivision of the state:

(a) shall allow the department to review the information the department may review under Subsection (3); and

(b) except for the Department of Public Safety, may not charge the department for access to the information.

(7) The department shall adopt measures to protect the security of the information it reviews under Subsection (3) and strictly limit access to the information to department employees responsible for processing an application for clearance.

(8) The department may disclose personal identification information specified under Subsection (4)(b) to the Department of Human Services to verify that the subject of the information is not identified as a perpetrator or offender in the information sources described in Subsections (3)(d) through (f).

(9) The department may establish fees, in accordance with Section 63J-1-504, for an application for clearance, which may include:

(a) the cost of obtaining and reviewing information under Subsection (3);

(b) a portion of the cost of creating and maintaining the Direct Access Clearance System database under Section 26-21-209; and

(c) other department costs related to the processing of the application and the ongoing review of information pursuant to Subsection (4)(a) to determine whether clearance should be retained.

Amended by Chapter 47, 2018 General Session

26-21-205 Department of Public Safety -- Retention of information -- Notification of Department of Health.

The Criminal Investigations and Technical Services Division within the Department of Public Safety shall:

(1) retain, separate from other division records, personal information, including any fingerprints, sent to it by the Department of Health pursuant to Subsection 26-21-204(3)(a); and

(2) notify the Department of Health upon receiving notice that an individual for whom personal information has been retained is the subject of:

(a) a warrant for arrest;

(b) an arrest;

(c) a conviction, including a plea in abeyance; or

(d) a pending diversion agreement.

Enacted by Chapter 328, 2012 General Session

26-21-206 Covered providers and covered contractors required to apply for clearance of certain individuals.

(1) As provided in Subsection (2), each covered provider and covered contractor operating in this state shall:

(a) collect from each covered individual it engages, and each individual it intends to engage as a covered individual, the personal identification information specified by the department under Subsection 26-21-204(4)(b); and

(b) submit to the department an application for clearance for the individual, including:

(i) the personal identification information; and

(ii) any fees established by the department under Subsection 26-21-204(9).

(2) Clearance granted for an individual pursuant to an application submitted by a covered provider or a covered contractor is valid until the later of:

(a) two years after the individual is no longer engaged as a covered individual; or

(b) the covered provider's or covered contractor's next license renewal date.

Enacted by Chapter 328, 2012 General Session

26-21-207 Covered providers required to apply for clearance for certain individuals other than residents residing in residential settings -- Certain individuals other than residents prohibited from residing in residential settings without clearance.

(1) A covered provider that provides services in a residential setting shall:
  (a) collect the personal identification information specified by the department under Subsection 26-21-204(4)(b) for each individual 12 years of age or older, other than a resident, who resides in the residential setting; and
  (b) submit to the department an application for clearance for the individual, including:
    (i) the personal identification information; and
    (ii) any fees established by the department under Subsection 26-21-204(9).
(2) A covered provider that provides services in a residential setting may allow an individual 12 years of age or older, other than a resident, to reside in the residential setting only if the individual has clearance.

Enacted by Chapter 328, 2012 General Session

26-21-208 Application for clearance by individuals.

(1) An individual may apply for clearance by submitting to the department an application, including:
  (a) the personal identification information specified by the department under Subsection 26-21-204(4)(b); and
  (b) any fees established by the department under Subsection 26-21-204(9).
(2) Clearance granted to an individual who makes application under Subsection (1) is valid for two years unless the department determines otherwise based on its ongoing review under Subsection 26-21-204(4)(a).

Enacted by Chapter 328, 2012 General Session

26-21-209 Direct Access Clearance System database -- Contents -- Use.

(1) The department shall create and maintain a Direct Access Clearance System database, which:
  (a) includes the names of individuals for whom the department has received:
    (i) an application for clearance under this part; or
    (ii) an application for background clearance under Section 26-8a-310; and
  (b) indicates whether an application is pending and whether clearance has been granted and retained for:
    (i) an applicant under this part; and
    (ii) an applicant for background clearance under Section 26-8a-310.
(2)
  (a) The department shall allow covered providers and covered contractors to access the database electronically.
  (b) Data accessible to a covered provider or covered contractor is limited to the information under Subsections (1)(a)(i) and (1)(b)(i) for:
    (i) covered individuals engaged by the covered provider or covered contractor; and
    (ii) individuals:
      (A) whom the covered provider or covered contractor could engage as covered individuals; and

(B) who have provided the covered provider or covered contractor with sufficient personal identification information to uniquely identify the individual in the database.

(c)

(i) The department may establish fees, in accordance with Section 63J-1-504, for use of the database by a covered contractor.

(ii) The fees may include, in addition to any fees established by the department under Subsection 26-21-204(9), an initial set-up fee, an ongoing access fee, and a per-use fee.

Amended by Chapter 307, 2015 General Session

26-21-210 No civil liability.

A covered body is not civilly liable for submitting to the department information required under this part or refusing to employ an individual who does not have clearance to have direct patient access under Section 26-21-203.

Enacted by Chapter 328, 2012 General Session

Part 3
Assisted Living Facilities

26-21-301 Title.

This part is known as "Assisted Living Facilities."

Amended by Chapter 220, 2018 General Session

26-21-302 Definitions.

As used in this part:

(1) "Facility" means an assisted living facility.

(2) "Legal representative" means an individual who is legally authorized to make health care decisions on behalf of another individual.

(3)

(a) "Monitoring device" means:

(i) a video surveillance camera; or

(ii) a microphone or other device that captures audio.

(b) "Monitoring device" does not include:

(i) a device that is specifically intended to intercept wire, electronic, or oral communication without notice to or the consent of a party to the communication; or

(ii) a device that is connected to the Internet or that is set up to transmit data via an electronic communication.

(4) "Ombudsman" means the same as that term is defined in Section 62A-3-202.

(5) "Resident" means an individual who receives health care from a facility.

(6) "Responsible person" means an individual who:

(a) is designated in writing by a resident to receive communication on behalf of the resident; or

(b) a legal representative.

(7) "Room" means a resident's private or shared primary living space.

(8) "Roommate" means an individual sharing a room with a resident.

Amended by Chapter 220, 2018 General Session

26-21-303 Monitoring device -- Installation, notice, and consent -- Liability.

(1) A resident or the resident's legal representative may operate or install a monitoring device in the resident's room if the resident and the resident's legal representative, if any, unless the resident is incapable of informed consent:
  (a) notifies the resident's facility in writing that the resident or the resident's legal representative, if any:
    (i) intends to operate or install a monitoring device in the resident's room; and
    (ii) consents to a waiver agreement, if required by a facility;
  (b) obtains written consent from each of the resident's roommates, and their legal representative, if any, that specifically states the hours when each roommate consents to the resident or the resident's legal representative operating the monitoring device; and
  (c) assumes all responsibility for any cost related to installing or operating the monitoring device.

(2) A facility shall not be civilly or criminally liable to:
  (a) a resident or resident's roommate for the operation of a monitoring device consistent with this part; and
  (b) any person other than the resident or resident's roommate for any claims related to the use or operation of a monitoring device consistent with this part, unless the claim is caused by the acts or omissions of an employee or agent of the facility.

(3) Notwithstanding any other provision of this part, an individual may not, under this part, operate a monitoring device in a facility without a court order:
  (a) in secret; or
  (b) with an intent to intercept a wire, electronic, or oral communication without notice to or the consent of a party to the communication.

Enacted by Chapter 141, 2016 General Session

26-21-304 Monitoring device -- Facility admission, patient discharge, and posted notice.

(1) A facility may not deny an individual admission to the facility for the sole reason that the individual or the individual's legal representative requests to install or operate a monitoring device in the individual's room.

(2) A facility may not discharge a resident for the sole reason that the resident or the resident's legal representative requests to install or operate a monitoring device in the individual's room.

(3) A facility may require the resident or the resident's legal representative to place a sign near the entrance of the resident's room that states that the room contains a monitoring device.

Enacted by Chapter 141, 2016 General Session

26-21-305 Transfer or discharge.

When a facility initiates the transfer or discharge of a resident, the facility shall:

(1) notify the resident and the resident's responsible person, if any, in writing and in a language and a manner that is most likely to be understood by the resident and the resident's responsible person, of:
  (a) the reasons for the transfer or discharge;
  (b) the effective date of the transfer or discharge;
  (c) the location to which the resident will be transferred or discharged, if known; and

(d) the name, address, email, and telephone number of the ombudsman;
(2) send a copy, in English, of the notice described in Subsection (1)(a) to the ombudsman on the same day on which the facility delivers the notice described in Subsection (1)(a) to the resident and the resident's responsible person;
(3) provide the notice described in Subsection (1)(a) at least 30 days before the day on which the resident is transferred or discharged, unless:
(a) notice for a shorter period of time is necessary to protect:
(i) the safety of individuals in the facility from endangerment due to the medical or behavioral status of the resident; or
(ii) the health of individuals in the facility from endangerment due to the resident's continued residency;
(b) an immediate transfer or discharge is required by the resident's urgent medical needs; or
(c) the resident has not resided in the facility for at least 30 days;
(4) update the transfer or discharge notice as soon as practicable before the transfer or discharge if information in the notice changes before the transfer or discharge;
(5) orally explain to the resident:
(a) the services available through the ombudsman; and
(b) the contact information for the ombudsman;
(6) provide and document the provision of preparation and orientation, in a language and manner the resident is most likely to understand, for a resident to ensure a safe and orderly transfer or discharge from the facility; and
(7) in the event of a facility closure, provide written notification of the closure to the ombudsman, each resident of the facility, and each resident's responsible person.

Enacted by Chapter 220, 2018 General Session

Chapter 21a
Cancer Programs

Part 1
Definitions

26-21a-101 Definitions.

As used in this chapter:
(1) "Breast cancer screening mammography" means a standard two-view per breast, low-dose as defined by the National Cancer Institute, radiographic examination of the breasts to detect unsuspected breast cancer using equipment designed and dedicated specifically for mammography.
(2) "Diagnostic mammography" means mammography performed on a woman having suspected breast cancer.
(3) "Facility" means a facility that provides screening or diagnostic breast mammography services.

Enacted by Chapter 126, 1991 General Session

Part 2
Mammogram Quality Assurance

26-21a-201 Short title.

This part is known as the "Mammogram Quality Assurance Act."

Enacted by Chapter 126, 1991 General Session

26-21a-203 Department rulemaking authority.

The department shall make rules under Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(1) establishing quality assurance standards for all facilities performing screening or diagnostic mammography and developing mammogram x-ray films, including notification and procedures for clinical follow-up of abnormal mammograms;

(2) providing for:

(a) collection and periodic reporting of mammography examinations and clinical follow-up data to the department;

(b) certification and revocation of certification of mammogram facilities;

(c) inspection of mammogram facilities, including entry of agents of the department into the facilities for inspections;

(d) setting fees for certification; and

(e) an appeal process regarding department certification decisions; and

(3) requiring a facility that is certified under Section 26-21a-204 to comply with the notification requirement described in Section 26-21a-206.

Amended by Chapter 217, 2018 General Session

26-21a-204 Mammogram provider certification.

(1) A mammogram may only be performed in a facility the department certifies as meeting:

(a) the qualifications and standards under Section 26-21a-203; and

(b) the registration, licensing, and inspection requirements for radiation sources under Section 19-3-104.

(2) Facilities desiring to perform mammograms shall request certification as a mammogram provider by the department under procedures established by department rule.

Amended by Chapter 286, 2001 General Session

26-21a-205 Department duties.

The department shall:

(1) enforce rules established under this part;

(2) implement and enforce the notice requirement in Section 26-21a-206;

(3) authorize qualified department agents to conduct inspections of mammogram facilities under department rules;

(4) collect and credit fees for certification established by the department in accordance with Section 63J-1-504; and

(5) provide necessary administrative and staff support to the committee.

Amended by Chapter 217, 2018 General Session

26-21a-206 Women's cancer screening notification requirement.

(1) As used in this section, "dense breast tissue" means heterogeneously dense tissue or extremely dense tissue as defined in the Breast Imaging and Reporting Data System established by the American College of Radiology.

(2) A facility that is certified under Section 26-21a-204 shall include the following notification and information with a mammography result provided to a patient with dense breast tissue:

"Your mammogram indicates that you have dense breast tissue. Dense breast tissue is common and is found in as many as half of all women. However, dense breast tissue can make it more difficult to fully and accurately evaluate your mammogram and detect early signs of possible cancer in the breast. This information is being provided to inform and encourage you to discuss your dense breast tissue and other breast cancer risk factors with your health care provider. Together, you can decide what may be best for you. A copy of your mammography report has been sent to your health care provider. Please contact them if you have any questions or concerns about this notice."

Enacted by Chapter 217, 2018 General Session

Part 3
Cancer Related Programs and Accounts

26-21a-301 Breast cancer mortality reduction program.

The department shall create a breast cancer mortality reduction program. The program shall include:

(1) education programs for health professionals regarding skills in cancer screening, diagnosis, referral, treatment, and rehabilitation based on current scientific knowledge;

(2) education programs to assist the public in understanding:

(a) the benefits of regular breast cancer screening;

(b) resources available in the medical care system for cancer screening, diagnosis, referral, treatment, and rehabilitation; and

(c) available options for treatment of breast cancer and the ramifications of each approach; and

(3) subsidized screening mammography for low-income women as determined by the department standards.

Enacted by Chapter 126, 1991 General Session

26-21a-302 Cancer Research Restricted Account.

(1) As used in this section, "account" means the Cancer Research Restricted Account created by this section.

(2) There is created in the General Fund a restricted account known as the "Cancer Research Restricted Account."

(3) The account shall be funded by:

(a) contributions deposited into the account in accordance with Section 41-1a-422;

(b) private contributions;

(c) donations or grants from public or private entities; and

(d) interest and earnings on fund money.
(4) The department shall distribute funds in the account to one or more charitable organizations that:
(a) qualify as being tax exempt under Section 501(c)(3) of the Internal Revenue Code;
(b) have been designated as an official cancer center of the state;
(c) is a National Cancer Institute designated cancer center; and
(d) have as part of its primary mission:
(i) cancer research programs in basic science, translational science, population science, and clinical research to understand cancer from its beginnings; and
(ii) the dissemination and use of knowledge developed by the research described in Subsection (4)(d)(i) for the creation and improvement of cancer detection, treatments, prevention, and outreach programs.
(5)
(a) An organization described in Subsection (4) may apply to the department to receive a distribution in accordance with Subsection (4).
(b) An organization that receives a distribution from the department in accordance with Subsection (4) shall expend the distribution only to conduct cancer research for the purpose of making improvements in cancer treatments, cures, detection, and prevention of cancer at the molecular and genetic levels.
(c) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules providing procedures for an organization to apply to the department to receive a distribution under Subsection (4).

Amended by Chapter 303, 2011 General Session

26-21a-304 Children with Cancer Support Restricted Account.
(1) As used in this section, "account" means the Children with Cancer Support Restricted Account created in this section.
(2) There is created in the General Fund a restricted account known as the "Children with Cancer Support Restricted Account."
(3) The account shall be funded by:
(a) contributions deposited into the account in accordance with Section 41-1a-422;
(b) private contributions;
(c) donations or grants from public or private entities; and
(d) interest and earnings on account money.
(4) Upon appropriation by the Legislature, the department shall distribute funds in the account to one or more charitable organizations that:
(a) qualify as tax exempt under Section 501(c)(3), Internal Revenue Code;
(b) are hospitals for children's tertiary care with board certified pediatric hematologist oncologists treating children, both on an inpatient and outpatient basis, with blood disorders and cancers from throughout the state;
(c) are members of a national organization devoted exclusively to childhood and adolescent cancer research;
(d) have pediatric nurses trained in hematology oncology;
(e) participate in one or more pediatric cancer clinical trials; and
(f) have programs that provide assistance to children with cancer.
(5)

(a) An organization described in Subsection (4) may apply to the department to receive a distribution in accordance with Subsection (4).
(b) An organization that receives a distribution from the department in accordance with Subsection (4) may expend the distribution only to create or support programs that provide assistance to children with cancer.
(c) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules providing procedures for an organization to apply to the department to receive a distribution under Subsection (4).

Enacted by Chapter 46, 2016 General Session

Chapter 21b
Sexual Assault Victim Protocols

Part 1
General Provisions

26-21b-101 Title.

This chapter is known as "Sexual Assault Victim Protocols."

Enacted by Chapter 266, 2009 General Session

26-21b-102 Definitions.

As used in this chapter:
(1) "Critical access hospital" means a critical access hospital that meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2) (1998).
(2) "Designated facility" means:
(a) a freestanding urgent care center;
(b) a general acute hospital; or
(c) a critical access hospital.
(3) "Emergency contraception" means the use of a substance, approved by the United States Food and Drug Administration, to prevent pregnancy after sexual intercourse.
(4) "Freestanding urgent care center" is as defined in Section 59-12-801.
(5) "General acute hospital" is as defined in Section 26-21-2.
(6) "Physician" means a person:
(a) licensed as a physician under Title 58, Chapter 67, Utah Medical Practice Act; or
(b) licensed as a physician under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(7) "Practitioner" means:
(a) a physician; or
(b) any other person who is permitted by law to prescribe emergency contraception.
(8) "Sexual assault" means any criminal conduct described in Title 76, Chapter 5, Part 4, Sexual Offenses, that may result in a pregnancy.
(9) "Victim of sexual assault" means any person who presents to receive, or receives, medical care in consequence of being subjected to sexual assault.

Amended by Chapter 140, 2010 General Session

Part 2
Emergency Contraception Services

26-21b-201 Emergency contraception services for a victim of sexual assault.

(1) Except as provided in Subsection (2), a designated facility shall provide the following services to a victim of sexual assault:

(a) provide the victim with written and oral medical information regarding emergency contraception that is unbiased, accurate, and generally accepted by the medical community as being scientifically valid;

(b) orally inform the victim of sexual assault that the victim may obtain emergency contraception at the designated facility;

(c) offer a complete regimen of emergency contraception to a victim of sexual assault;

(d) provide, at the designated facility, emergency contraception to the victim of sexual assault upon her request;

(e) maintain a protocol, prepared by a physician, for the administration of emergency contraception at the designated facility to a victim of sexual assault; and

(f) develop and implement a written policy to ensure that a person is present at the designated facility, or on-call, who:

(i) has authority to dispense or prescribe emergency contraception, independently, or under the protocol described in Subsection (1)(e), to a victim of sexual assault; and

(ii) is trained to comply with the requirements of this section.

(2) A freestanding urgent care center is exempt from the requirements of Subsection (1) if:

(a) there is a general acute hospital or a critical access hospital within 30 miles of the freestanding urgent care center; and

(b) an employee of the freestanding urgent care center provides the victim with:

(i) written and oral medical information regarding emergency contraception that is unbiased, accurate, and generally accepted by the medical community as being scientifically valid; and

(ii) the name and address of the general acute hospital or critical access hospital described in Subsection (2)(a).

(3) A practitioner shall comply with Subsection (4) with regard to a person who is a victim of sexual assault, if the person presents to receive medical care, or receives medical care, from the practitioner at a location that is not a designated facility.

(4) A practitioner described in Subsection (3) shall:

(a) provide the victim with written and oral medical information regarding emergency contraception that is unbiased, accurate, and generally accepted by the medical community as being scientifically valid; and

(b)

(i)

(A) orally inform the victim of sexual assault that the victim may obtain emergency contraception at the facility where the practitioner is located; and

(B) provide emergency contraception to the victim of sexual assault, if she requests emergency contraception; or

(ii) inform the victim of sexual assault of the nearest location where she may obtain emergency contraception.

Amended by Chapter 140, 2010 General Session

Part 3
Investigation and Enforcement

26-21b-301 Investigation and enforcement.

(1) The department may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to enforce the provisions of this chapter.
(2) The department shall, in an expeditious manner, investigate any complaint received by the department regarding the failure of a health care facility to comply with a requirement of this chapter.
(3) If the department finds a violation of this chapter, or any rules adopted pursuant to this chapter, the department may take one or more of the actions described in Section 26-21-11.

Enacted by Chapter 266, 2009 General Session

Chapter 23
Enforcement Provisions and Penalties

26-23-1 Legal advice and representation for department.

(1) The attorney general shall be the legal adviser for the department and the executive director and shall defend them in all actions and proceedings brought against either of them. The county attorney of the county in which a cause of action arises or a public offense occurs shall bring any civil action requested by the executive director to abate a condition which exists in violation of the public health laws or standards, orders, and rules of the department as provided in Section 26-23-6.
(2) The district attorney or county attorney having criminal jurisdiction shall prosecute for the violation of the public health laws or standards, orders, and rules of the department as provided in Section 26-23-6.
(3) If the county attorney or district attorney fails to act, the executive director may bring any such action and shall be represented by the attorney general or, with the approval of the attorney general, by special counsel.

Amended by Chapter 38, 1993 General Session

26-23-2 Administrative review of actions of department or director.

Any person aggrieved by any action or inaction of the department or its executive director may request an adjudicative proceeding by following the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act.

Amended by Chapter 382, 2008 General Session

26-23-3 Violation of public health laws or orders unlawful.

It shall be unlawful for any person, association, or corporation, and the officers thereof:
(1) to willfully violate, disobey, or disregard the provisions of the public health laws or the terms of any lawful notice, order, standard, rule, or regulation issued thereunder; or
(2) to fail to remove or abate from private property under the person's control at his own expense, within 48 hours, or such other reasonable time as the health authorities shall determine, after being ordered to do so by the health authorities, any nuisance, source of filth, cause of sickness, dead animal, health hazard, or sanitation violation within the jurisdiction and control of the department, whether the person, association, or corporation shall be the owner, tenant, or occupant of such property; provided, however, when any such condition is due to an act of God, it shall be removed at public expense; or
(3) to pay, give, present, or otherwise convey to any officer or employee of the department any gift, remuneration or other consideration, directly or indirectly, which such officer or employee is forbidden to receive by the provisions of this chapter;
(4) to fail to make or file reports required by law or rule of the department relating to the existence of disease or other facts and statistics relating to the public health.

Enacted by Chapter 126, 1981 General Session

26-23-4 Unlawful acts by department officers and employees.

It shall be unlawful for any officer or employee of the department:
(1) To accept any gift, remuneration, or other consideration, directly or indirectly, for an incorrect or improper performance of the duties imposed upon him by or in behalf of the department or by the provisions of this chapter.
(2) To perform any work, labor, or services other than the duties assigned to him on behalf of the department during the hours such officer or employee is regularly employed by the department, or to perform his duties as an officer or employee of the department under any condition or arrangement that involves a violation of this or any other law of the state.

Enacted by Chapter 126, 1981 General Session

26-23-5 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.

Amended by Chapter 202, 1995 General Session

26-23-5.5 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.

Enacted by Chapter 202, 1995 General Session

26-23-6 Criminal and civil penalties and liability for violations.

(1)
  (a) Any person, association, or corporation, or the officers of any of them, who violates any provision of this chapter or lawful orders of the department or a local health department in a criminal proceeding is guilty of a class B misdemeanor for the first violation, and for any subsequent similar violation within two years, is guilty of a class A misdemeanor, except this section does not establish the criminal penalty for violation of Section 26-23-5.5.
  (b) Conviction in a criminal proceeding does not preclude the department or a local health department from assessment of any civil penalty, administrative civil money penalty or to deny, revoke, condition, or refuse to renew a permit, license, or certificate or to seek other injunctive or equitable remedies.
(2) Any person, association, or corporation, or the officers of any of them, who violates any provision of this title or lawful orders of the department or a local health department, or rules adopted under this title by the department:
  (a) shall be assessed, in a judicial civil proceeding, a penalty not to exceed the sum of $10,000 per violation; or
  (b) in an administrative action in accordance with Title 63G, Chapter 4, Administrative Procedures Act, or similar procedures adopted by local or county government, a penalty not to exceed the sum of $10,000 per violation.
(3) Assessment of any civil penalty or administrative penalty does not preclude the department or a local health department from seeking criminal penalties or to deny, revoke, impose conditions on, or refuse to renew a permit, license, or certificate or to seek other injunctive or equitable remedies.
(4) In addition to any penalties imposed under Subsection (1), the person, association, or corporation, or the officers of any of them is liable for any expense incurred by the department in removing or abating any health or sanitation violations, including any nuisance, source of filth, cause of sickness, or dead animal.

(5) Each day of violation of a provision of this title, lawful orders of the department or a local health department, or rules adopted by the department under it is a separate violation.

Amended by Chapter 347, 2009 General Session

26-23-7 Application of enforcement procedures and penalties.

Enforcement procedures and penalties provided in this chapter do not apply to other chapters in this title which provide for specific enforcement procedures and penalties.

Amended by Chapter 297, 2011 General Session

26-23-8 Representatives of department authorized to enter regulated premises.

Authorized representatives of the department upon presentation of appropriate identification shall be authorized to enter upon the premises of properties regulated under this title to perform routine inspections to insure compliance with rules adopted by the department. This section does not authorize the department to inspect private dwellings.

Enacted by Chapter 126, 1981 General Session

26-23-9 Authority of department as to functions transferred from other agencies.

(1) If functions transferred from other agencies are vested by this code in the department, the department shall be the successor in every way, with respect to such functions, except as otherwise provided by this code. Every act done in the exercise of such functions by the department shall have the same force and effect as if done by the agency in which the functions were previously vested.
(2) Whenever any such agency is referred to or designated by law, contract, or other document, the reference or designation shall apply to the department.

Enacted by Chapter 126, 1981 General Session

26-23-10 Religious exemptions from code -- Regulation of state-licensed healing system practice unaffected by code.

(1)
  (a) Except as provided in Subsection (1)(b), nothing in this code shall be construed to compel any person to submit to any medical or dental examination or treatment under the authority of this code when such person, or the parent or guardian of any such person objects to such examination or treatment on religious grounds, or to permit any discrimination against such person on account of such objection.
  (b) An exemption from medical or dental examination, described in Subsection (1)(a), may not be granted if the executive director has reasonable cause to suspect a substantial menace to the health of other persons exposed to contact with the unexamined person.
(2) Nothing in this code shall be construed as authorizing the supervision, regulation, or control of the remedial care or treatment of residents in any home or institution conducted for those who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any well recognized church or religious denomination, provided the statutes and regulations on sanitation are complied with.
(3) Nothing in this code shall be construed or used to amend any statute now in force pertaining to the scope of practice of any state-licensed healing system.

Amended by Chapter 297, 2011 General Session

Chapter 23a
Injury Reporting by Health Care Providers

26-23a-1 Definitions.

As used in this chapter:

(1) "Health care provider" means any person, firm, corporation, or association which furnishes treatment or care to persons who have suffered bodily injury, and includes hospitals, clinics, podiatrists, dentists and dental hygienists, nurses, nurse practitioners, physicians and physicians' assistants, osteopathic physicians, naturopathic practitioners, chiropractors, acupuncturists, paramedics, and emergency medical technicians.

(2) "Injury" does not include any psychological or physical condition brought about solely through the voluntary administration of prescribed controlled substances.

(3) "Law enforcement agency" means the municipal or county law enforcement agency:

(a) having jurisdiction over the location where the injury occurred; or

(b) if the reporting health care provider is unable to identify or contact the law enforcement agency with jurisdiction over the injury, "law enforcement agency" means the agency nearest to the location of the reporting health care provider.

(4) "Report to a law enforcement agency" means to report, by telephone or other spoken communication, the facts known regarding an injury subject to reporting under Section 26-23a-2 to the dispatch desk or other staff person designated by the law enforcement agency to receive reports from the public.

Amended by Chapter 23, 1996 General Session

26-23a-2 Injury reporting requirements by health care provider -- Contents of report.

(1)

(a) Any health care provider who treats or cares for any person who suffers from any wound or other injury inflicted by the person's own act or by the act of another by means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state, shall immediately report to a law enforcement agency the facts regarding the injury.

(b) The report shall state the name and address of the injured person, if known, the person's whereabouts, the character and extent of the person's injuries, and the name, address, and telephone number of the person making the report.

(2) A health care provider may not be discharged, suspended, disciplined, or harassed for making a report pursuant to this section.

(3) A person may not incur any civil or criminal liability as a result of making any report required by this section.

(4) A health care provider who has personal knowledge that the report of a wound or injury has been made in compliance with this section is under no further obligation to make a report regarding that wound or injury under this section.

Amended by Chapter 23, 1996 General Session

26-23a-3 Penalties.

Any health care provider who intentionally or knowingly violates any provision of Section 26-23a-2 is guilty of a class B misdemeanor.

Enacted by Chapter 238, 1988 General Session

Chapter 23b
Detection of Public Health Emergencies Act

26-23b-101 Title.

This chapter is known as the "Detection of Public Health Emergencies Act."

Enacted by Chapter 155, 2002 General Session

26-23b-102 Definitions.

As used in this chapter:

(1) "Bioterrorism" means:

(a) the intentional use of any microorganism, virus, infectious substance, or biological product to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence, intimidate, or coerce the conduct of government or a civilian population; and

(b) includes anthrax, botulism, small pox, plague, tularemia, and viral hemorrhagic fevers.

(2) "Department" means the Department of Health created in Section 26-1-4 and a local health department as defined in Section 26A-1-102.

(3) "Diagnostic information" means a clinical facility's record of individuals who present for treatment, including the reason for the visit, chief complaint, presenting diagnosis, final diagnosis, and any pertinent lab results.

(4) "Epidemic or pandemic disease":

(a) means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy; and

(b) includes diseases designated by the Department of Health which have the potential to cause serious illness or death.

(5) "Health care provider" shall have the meaning provided for in Section 78B-3-403.

(6) "Public health emergency" means an occurrence or imminent credible threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability. Such illness or health condition includes an illness or health condition resulting from a natural disaster.

(7) "Reportable emergency illness and health condition" includes the diseases, conditions, or syndromes designated by the Utah Department of Health.

Amended by Chapter 3, 2008 General Session

26-23b-103 Mandatory reporting requirements -- Contents of reports -- Penalties.

(1)

(a) A health care provider shall report to the department any case of any person who the provider knows has a confirmed case of, or who the provider believes in his professional judgment is sufficiently likely to harbor any illness or health condition that may be caused by:
(i) bioterrorism;
(ii) epidemic or pandemic disease; or
(iii) novel and highly fatal infectious agents or biological toxins which might pose a substantial risk of a significant number of human fatalities or incidences of permanent or long-term disability.
(b) A health care provider shall immediately submit the report required by Subsection (1)(a) within 24 hours of concluding that a report is required under Subsection (1)(a).
(2)
(a) A report required by this section shall be submitted electronically, verbally, or in writing to the department or appropriate local health department.
(b) A report submitted pursuant to Subsection (1) shall include, if known:
(i) diagnostic information on the specific illness or health condition that is the subject of the report, and, if transmitted electronically, diagnostic codes assigned to the visit;
(ii) the patient's name, date of birth, sex, race, occupation, and current home and work address and phone number;
(iii) the name, address, and phone number of the health care provider; and
(iv) the name, address, and phone number of the reporting individual.
(3) The department may impose a sanction against a health care provider for failure to make a report required by this section only if the department can show by clear and convincing evidence that a health care provider willfully failed to file a report.

Enacted by Chapter 155, 2002 General Session

26-23b-104 Authorization to report.
(1) A health care provider is authorized to report to the department any case of a reportable emergency illness or health condition in any person when:
(a) the health care provider knows of a confirmed case; or
(b) the health care provider believes, based on the health care provider's professional judgment that a person likely harbors a reportable emergency illness or health condition.
(2) A report pursuant to this section shall include, if known:
(a) the name of the facility submitting the report;
(b) a patient identifier that allows linkage with the patient's record for follow-up investigation if needed;
(c) the date and time of visit;
(d) the patient's age and sex;
(e) the zip code of the patient's residence;
(f) the reportable illness or condition detected or suspected;
(g) diagnostic information and, if available, diagnostic codes assigned to the visit; and
(h) whether the patient was admitted to the hospital.
(3)
(a) If the department determines that a public health emergency exists, the department may, with the concurrence of the governor and the executive director or in the absence of the executive director, the executive director's designee, issue a public health emergency order and mandate reporting under this section for a limited reasonable period of time, as necessary to respond to the public health emergency.

(b) The department may not mandate reporting under this subsection for more than 90 days. If more than 90 days is needed to abate the public health emergency declared under Subsection (3)(a), the department shall obtain the concurrence of the governor to extend the period of time beyond 90 days.

(4)

(a) Unless the provisions of Subsection (3) apply, a health care provider is not subject to penalties for failing to submit a report under this section.

(b) If the provisions of Subsection (3) apply, a health care provider is subject to the penalties of Subsection 26-23b-103(3) for failure to make a report under this section.

Amended by Chapter 297, 2011 General Session

26-23b-105 Pharmacy reporting requirements.

(1) Notwithstanding the provisions of Subsection 26-23b-103(1)(a), a pharmacist shall report unusual drug-related events as described in Subsection (2).

(2) Unusual drug-related events that require a report include:

(a) an unusual increase in the number of prescriptions filled for antimicrobials;

(b) any prescription that treats a disease that has bioterrorism potential if that prescription is unusual or in excess of the expected frequency; and

(c) an unusual increase in the number of requests for information about or sales of over-the-counter pharmaceuticals to treat conditions which may suggest the presence of one of the illnesses or conditions described in Section 26-23b-103 or 26-23b-104 and which are designated by department rule.

(3)

(a) A pharmacist shall submit the report required by this section within 24 hours after the pharmacist suspects, in his professional judgement, that an unusual drug-related event has occurred.

(b) If a pharmacy is part of a health care facility subject to the reporting requirements of this chapter, the pharmacist in charge shall make the report under this section on behalf of the health care facility.

(4)

(a) The report required by this section shall be submitted in accordance with Subsection 26-23b-103(2)(a).

(b) A report shall include the name and location of the reporting pharmacist, the name and type of pharmaceuticals that are the subject of the unusual increase in use, and if known, the suspected illness or health condition that is the subject of the report.

(5) A pharmacist is subject to the penalties under Subsection 26-23b-103(3) for failing to make a report required by this section.

Enacted by Chapter 155, 2002 General Session

26-23b-106 Medical laboratory reporting requirements.

(1) Notwithstanding the provisions of Subsection 26-23b-103(1), the director of a medical laboratory located in this state is responsible for reporting results of a laboratory test that confirm a condition or illness described in Subsection 26-23b-103(1) within 24 hours after obtaining the results of the test. This reporting requirement also applies to results obtained on specimens sent to an out-of-state laboratory for analysis.

(2) The director of a medical laboratory located outside this state that receives a specimen obtained inside this state is responsible for reporting the results of any test that confirm a condition or illness described in Subsection 26-23b-103(1), within 24 hours of obtaining the results, provided that the laboratory that performs the test has agreed to the reporting requirements of this state.
(3) If a medical laboratory is part of a health care facility subject to the reporting requirements of this chapter, the director of the medical laboratory shall make the report required by this section on behalf of the health care facility.
(4) The report required by this section shall be submitted in accordance with Subsection 26-23b-103(2).
(5) The director of a medical laboratory is subject to the penalties of Subsection 26-23b-103(3) for failing to make a report required by this section.

Enacted by Chapter 155, 2002 General Session

26-23b-107 Exemptions from liability.
(1) A health care provider may not be discharged, suspended, disciplined, or harassed for making a report pursuant to this chapter.
(2) A health care provider may not incur any civil or criminal liability as a result of making any report under this chapter so long as the report is made in good faith.

Enacted by Chapter 155, 2002 General Session

26-23b-108 Investigation of suspected bioterrorism and diseases.
(1) The department shall:
  (a) ascertain the existence of cases of an illness or condition caused by the factors described in Subsections 26-23b-103(1) and 26-23b-104(1);
  (b) investigate all such cases for sources of infection or exposure;
  (c) ensure that any cases, suspected cases, and exposed persons are subject to proper control measures; and
  (d) define the distribution of the suspected illness or health condition.
(2)
  (a) Acting on information received from the reports required by this chapter, or other reliable information, the department shall identify all individuals thought to have been exposed to an illness or condition described in Subsection 26-23b-103(1).
  (b) The department may request information from a health care provider concerning an individual's identifying information as described in Subsection 26-23b-103(2)(b) when:
    (i) the department is investigating a potential illness or condition described in Subsection 26-23b-103(1) and the health care provider has not submitted a report to the department with the information requested; or
    (ii) the department has received a report from a pharmacist under Section 26-23b-105, a medical laboratory under Section 26-23b-106, or another health care provider under Subsection 26-23b-104(1) and the department believes that further investigation is necessary to protect the public health.
  (c) A health care provider shall submit the information requested under this section to the department within 24 hours after receiving a request from the department.
(3) The department shall counsel and interview identified individuals as appropriate to:
  (a) assist in the positive identification of other cases and exposed individuals;

(b) develop information relating to the source and spread of the illness or condition; and
(c) obtain the names, addresses, phone numbers, or other identifying information of any other person from whom the illness or health condition may have been contracted and to whom the illness or condition may have spread.
(4) The department shall, for examination purposes, close, evacuate, or decontaminate any facility when the department reasonably believes that such facility or material may endanger the public health due to a condition or illness described in Subsection 26-23b-103(1).
(5) The department will destroy personally identifying health information about an individual collected by the department as a result of a report under this chapter upon the earlier of:
(a) the department's determination that the information is no longer necessary to carry out an investigation under this chapter; or
(b) 180 days after the information is collected.

Enacted by Chapter 155, 2002 General Session

26-23b-109 Enforcement.

The department may enforce the provisions of this chapter in accordance with existing enforcement laws and regulations.

Enacted by Chapter 155, 2002 General Session

26-23b-110 Information sharing with public safety authorities.

(1) For purposes of this section, "public safety authority" means a local, state, or federal law enforcement authority including the Division of Emergency Management, emergency medical services personnel, and firefighters.
(2) Notwithstanding the provisions of Title 63G, Chapter 2, Government Records Access and Management Act:
(a) whenever a public safety authority suspects a case of a reportable illness or condition under the provisions of this chapter, it shall immediately notify the department;
(b) whenever the department learns of a case of a reportable illness or condition under this chapter that it reasonably believes has the potential to be caused by one of the factors listed in Subsection 26-23b-103(1), it shall immediately notify the appropriate public safety authority; and
(c) sharing of information reportable under the provisions of this chapter between persons authorized by this chapter shall be limited to information necessary for the treatment, control, investigation, and prevention of a public health emergency.
(3) Except to the extent inconsistent with this chapter, Sections 26-6-27 and 26-6-28 apply to this chapter.

Amended by Chapter 55, 2011 General Session

Chapter 25
Confidential Information Release

26-25-1 Authority to provide data on treatment and condition of persons to designated agencies -- Immunity from liability.

(1) Any person, health facility, or other organization may, without incurring liability, provide the following information to the persons and entities described in Subsection (2):
  (a) information as determined by the state registrar of vital records appointed under Title 26, Chapter 2, Utah Vital Statistics Act;
  (b) interviews;
  (c) reports;
  (d) statements;
  (e) memoranda;
  (f) familial information; and
  (g) other data relating to the condition and treatment of any person.
(2) The information described in Subsection (1) may be provided to:
  (a) the department and local health departments;
  (b) the Division of Substance Abuse and Mental Health within the Department of Human Services;
  (c) scientific and health care research organizations affiliated with institutions of higher education;
  (d) the Utah Medical Association or any of its allied medical societies;
  (e) peer review committees;
  (f) professional review organizations;
  (g) professional societies and associations; and
  (h) any health facility's in-house staff committee for the uses described in Subsection (3).
(3) The information described in Subsection (1) may be provided for the following purposes:
  (a) study and advancing medical research, with the purpose of reducing the incidence of disease, morbidity, or mortality; or
  (b) the evaluation and improvement of hospital and health care rendered by hospitals, health facilities, or health care providers.
(4) Any person may, without incurring liability, provide information, interviews, reports, statements, memoranda, or other information relating to the ethical conduct of any health care provider to peer review committees, professional societies and associations, or any in-hospital staff committee to be used for purposes of intraprofessional society or association discipline.
(5) No liability may arise against any person or organization as a result of:
  (a) providing information or material authorized in this section;
  (b) releasing or publishing findings and conclusions of groups referred to in this section to advance health research and health education; or
  (c) releasing or publishing a summary of these studies in accordance with this chapter.
(6) As used in this chapter:
  (a) "health care provider" has the meaning set forth in Section 78B-3-403; and
  (b) "health care facility" has the meaning set forth in Section 26-21-2.

Amended by Chapter 3, 2008 General Session

26-25-2 Restrictions on use of data.
(1) The information described in Subsection 26-25-1(1) that is provided to the entities described in Subsection 26-25-1(2) shall:
  (a) be used and disclosed by the entities described in Subsection 26-25-1(2) in accordance with this chapter; and
  (b) is not subject to Title 63G, Chapter 2, Government Records Access and Management Act.
(2) The Division of Substance Abuse and Mental Health within the Department of Human Services, scientific and health care research organizations affiliated with institutions of higher education,

the Utah Medical Association or any of its allied medical societies, peer review committees, professional review organizations, professional societies and associations, or any health facility's in-house staff committee may only use or publish the information or material received or gathered under Section 26-25-1 for the purpose of study and advancing medical research or medical education in the interest of reducing the incidence of disease, morbidity, or mortality, except that a summary of studies conducted in accordance with Section 26-25-1 may be released by those groups for general publication.

Amended by Chapter 382, 2008 General Session

26-25-3 Information considered privileged communications.

All information, interviews, reports, statements, memoranda, or other data furnished by reason of this chapter, and any findings or conclusions resulting from those studies are privileged communications and are not subject to discovery, use, or receipt in evidence in any legal proceeding of any kind or character.

Amended by Chapter 201, 1996 General Session

26-25-4 Information held in confidence -- Protection of identities.

(1) All information described in Subsection 26-25-1(1) that is provided to a person or organization described in Subsection 26-25-1(2) shall be held in strict confidence by that person or organization, and any use, release, or publication resulting therefrom shall be made only for the purposes described in Subsection 26-25-1(3) and Section 26-25-2 and shall preclude identification of any individual or individuals studied.
(2) Notwithstanding Subsection (1), the department's use and disclosure of information is not governed by this chapter.

Amended by Chapter 242, 2003 General Session

26-25-5 Violation of chapter a misdemeanor -- Civil liability.

(1) Any use, release or publication, negligent or otherwise, contrary to the provisions of this chapter is a class B misdemeanor.
(2) Subsection (1) does not relieve the person or organization responsible for such use, release, or publication from civil liability.

Amended by Chapter 297, 2011 General Session

Chapter 26
Experimental Animals

26-26-1 "Institution" defined.

As used in this chapter, "institution" means any school or college of agriculture, veterinary medicine, medicine, pharmacy, dentistry or other educational, hospital or scientific establishment properly concerned with the investigation of or instruction concerning the structure or functions of living organisms, the cause, prevention, control or cure of diseases or abnormal condition of human beings or animals.

Enacted by Chapter 126, 1981 General Session

26-26-2 Authorization for institutions to obtain impounded animals.

Institutions may apply to the department for authorization to obtain animals from establishments maintained for the impounding, care and disposal of animals seized by lawful authority. If, after investigation, the department finds that the institution meets the requirements of this chapter and its rules and that the public interest will be served thereby, it may authorize the institution to obtain animals under this chapter.

Enacted by Chapter 126, 1981 General Session

26-26-3 Minimum period of impoundment -- Efforts required to contact owner and to make animal available -- Prerogative of person voluntarily providing animal.

(1) Subject to Subsection (2), the governing body of the county or municipality in which an establishment is located may make available to an authorized institution as many impounded animals in that establishment as the institution may request.

(2) A governing body described in Subsection (1) may not make an impounded animal available to an institution, unless:

(a) the animal has been legally impounded for the longer of:

(i) at least five days; or

(ii) the minimum period provided for by local ordinance;

(b) the animal has not been claimed or redeemed by:

(i) the animal's owner; or

(ii) any other person entitled to claim or redeem the animal; and

(c) the establishment has made a reasonable effort to:

(i) find the rightful owner of the animal, including checking if the animal has a tag or microchip; and

(ii) if the owner is not found, make the animal available to others during the impound period. Owners of animals who voluntarily provide their animals to an establishment may, by signature, determine whether or not the animal may be provided to an institution or used for research or educational purposes.

Amended by Chapter 241, 2010 General Session

26-26-4 Institution to pay transportation expense -- Restrictions on use of animals -- Fee.

The authorized institution shall provide, at its own expense, for the transportation of such animals from the establishment to the institution and shall use them only in the conduct of scientific and educational activities and for no other purpose. The institution shall reimburse the establishment for animals received. The fee shall be, at a minimum, $15 for cats and $20 for dogs. That fee shall be increased as determined by the department, based on fluctuations or changes in the Consumer Price Index.

Amended by Chapter 80, 1989 General Session

26-26-5 Records of animals required.

Each establishment referred to in Section 26-26-2 shall keep a public record of all animals received and disposed of.

Enacted by Chapter 126, 1981 General Session

26-26-6 Revocation of authorization.

The department upon 15 days written notice and an opportunity to be heard, may revoke an institution's authorization if the institution has violated any provision of this chapter, or has failed to comply with the conditions required by the department in respect to the issuance of authorization.

Enacted by Chapter 126, 1981 General Session

26-26-7 Adoption of rules by department -- Inspection and investigation of institutions.

(1) In carrying out the provisions of this chapter, the department may adopt rules for:
  (a) controlling the humane use of animals;
  (b) diagnosis and treatment of human and animal diseases;
  (c) advancement of veterinary, dental, medical, and biological sciences; and
  (d) testing, improvement, and standardization of laboratory specimens, biologic projects, pharmaceuticals, and drugs.
(2) The department may inspect or investigate any institution that applies for or is authorized to obtain animals.

Amended by Chapter 80, 1989 General Session

Chapter 28
Revised Uniform Anatomical Gift Act

26-28-101 Title.

This chapter is known as the "Revised Uniform Anatomical Gift Act."

Enacted by Chapter 60, 2007 General Session

26-28-102 Definitions.

As used in this chapter:
(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.

Enacted by Chapter 60, 2007 General Session

26-28-103 Applicability.

This chapter applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

Enacted by Chapter 60, 2007 General Session

26-28-104 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.

Enacted by Chapter 60, 2007 General Session

26-28-105 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.

Amended by Chapter 297, 2011 General Session

26-28-106 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).

Amended by Chapter 297, 2011 General Session

26-28-107 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.

Amended by Chapter 297, 2011 General Session

26-28-108 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.

Enacted by Chapter 60, 2007 General Session

26-28-109 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.

Amended by Chapter 48, 2018 General Session

26-28-110 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.

Enacted by Chapter 60, 2007 General Session

26-28-111 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.

Amended by Chapter 297, 2011 General Session

26-28-112 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.

Amended by Chapter 189, 2014 General Session

26-28-113 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.

Enacted by Chapter 60, 2007 General Session

26-28-114 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.

Amended by Chapter 349, 2019 General Session

26-28-115 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.

Enacted by Chapter 60, 2007 General Session

26-28-116 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.

Enacted by Chapter 60, 2007 General Session

26-28-117 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.

Enacted by Chapter 60, 2007 General Session

26-28-118 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.

Amended by Chapter 48, 2018 General Session

26-28-119 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.

Enacted by Chapter 60, 2007 General Session

26-28-120 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).

Amended by Chapter 297, 2011 General Session

26-28-121 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.

Amended by Chapter 297, 2011 General Session

26-28-122 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.

Enacted by Chapter 60, 2007 General Session

26-28-123 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).

Enacted by Chapter 60, 2007 General Session

26-28-124 Uniformity of application and construction.

In applying and construing this uniform act, consideration shall be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

Amended by Chapter 297, 2011 General Session

26-28-125 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).

Enacted by Chapter 60, 2007 General Session

Chapter 29
Elimination of Architectural Barriers for Persons with a Disability

26-29-1 Buildings and facilities to which chapter applies -- Standards available to interested parties -- Building board staff to advise, review, and approve plans when possible.

(1)
  (a) The standards in this chapter apply to all buildings and facilities used by the public that are constructed or remodeled in whole or in part by the use of state funds, or the funds of any political subdivision of the state.
  (b) All of those buildings and facilities constructed in Utah after May 12, 1981, shall conform to the standard prescribed in this chapter except buildings, facilities, or portions of them, not intended for public use, including:
    (i) caretaker dwellings;
    (ii) service buildings; and
    (iii) heating plants.

(2) This chapter applies to temporary or emergency construction as well as permanent buildings.

(3)
  (a) The standards established in this chapter apply to the remodeling or alteration of any existing building or facility within the jurisdictions set forth in this chapter where the remodeling or alteration will affect an area of the building or facility in which there are architectural barriers for persons with a physical disability.
  (b) If the remodeling involves less than 50% of the space of the building or facility, only the areas being remodeled need comply with the standards.

(c) If remodeling involves 50% or more of the space of the building or facility, the entire building or facility shall be brought into compliance with the standards.

(4)

(a) All individuals and organizations are encouraged to apply the standards prescribed in this chapter to all buildings used by the public, but that are financed from other than public funds.

(b) The State Building Board shall:

(i) make the standards established by this chapter available to interested individuals and organizations; and

(ii) upon request and to the extent possible, make available the services of the building board staff to advise, review, and approve plans and specifications in order to comply with the standards of this chapter.

Amended by Chapter 73, 2001 General Session

26-29-2 Purpose of chapter.

(1) This chapter is concerned with nonambulatory disabilities, semiambulatory disabilities, sight disabilities, hearing disabilities, disabilities of incoordination, and aging.

(2) It is intended to make all buildings and facilities covered by this chapter accessible to, and functional for, persons with a physical disability.

Amended by Chapter 73, 2001 General Session

26-29-3 Basis for standards.

The standards of this chapter are the current edition of planning and design criteria to prevent architectural barriers for the aged and persons with a physical disability, as promulgated by the State Building Board.

Amended by Chapter 73, 2001 General Session

26-29-4 Enforcement of chapter.

The responsibility for adoption of the planning and design criteria referred to in Section 26-29-3, and enforcement of this chapter shall be as follows:

(1) where state school funds are utilized, the State Board of Education.

(2) where state funds are utilized, the State Building Board.

(3) where funds of political subdivisions are utilized, the governing board of the county or municipality in which the building or facility is located.

Enacted by Chapter 126, 1981 General Session

Chapter 31
Human Blood Act

Part 1
General Provisions

26-31-101 Title.

This chapter is known as the "Human Blood Act."

Enacted by Chapter 90, 2011 General Session

26-31-102 Definitions.

As used in this chapter:

(1) "Blood" means human blood.

(2) "Blood product" includes:

(a) whole blood;

(b) blood plasma;

(c) a blood derivative;

(d) blood platelets; and

(e) blood clotting agents.

Enacted by Chapter 90, 2011 General Session

Part 2
Blood Procurement and Use

26-31-201 Procurement and use of a blood product is a service and not a sale.

The following are considered to be the rendition of a service by each participant and are not considered to be a sale:

(1) the procurement, processing, distribution, or use of a blood product for the purpose of injecting or transfusing the blood product into the human body; and

(2) the process of injecting or transfusing a blood product.

Renumbered and Amended by Chapter 90, 2011 General Session
Amended by Chapter 297, 2011 General Session

26-31-202 Blood donation by a minor.

A minor who is at least 16 years old may donate blood to a voluntary, noncompensatory blood donation program if a parent or legal guardian of the minor consents to the donation.

Enacted by Chapter 90, 2011 General Session

Chapter 33a
Utah Health Data Authority Act

26-33a-101 Short title.

This chapter is known as the "Utah Health Data Authority Act."

Enacted by Chapter 305, 1990 General Session

26-33a-102 Definitions.

As used in this chapter:

(1) "Committee" means the Health Data Committee created by Section 26-1-7.

(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.

(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) "Executive director" means the director of the department.

(6)

(a) "Health care facility" means a facility that is licensed by the department under Title 26, Chapter 21, 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.

(7) "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.

(8) "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 shall be excluded.

(9) "Health maintenance organization" has the meaning set forth in Section 31A-8-101.

(10) "Identifiable health data" means any item, collection, or grouping of health data that makes the individual supplying or described in the health data identifiable.

(11) "Individual" means a natural person.

(12) "Organization" means any corporation, association, partnership, agency, department, unit, or other legally constituted institution or entity, or part thereof.

(13) "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.

(14) "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.

(15) "Plan" means the plan developed and adopted by the Health Data Committee under Section 26-33a-104.
(16) "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.

Amended by Chapter 349, 2019 General Session

26-33a-103 Committee membership -- Terms -- Chair -- Compensation.
(1) The Health Data Committee created by Section 26-1-7 shall be composed of 15 members.
(2)
(a) One member shall be:
(i) the commissioner of the Utah Insurance Department; or
(ii) the commissioner's designee who shall have knowledge regarding the health care system and characteristics and use of health data.
(b) Fourteen members shall be appointed by the governor with the consent of the Senate in accordance with Subsection (3). No more than seven members of the committee appointed by the governor may be members of the same political party.
(3) The members of the committee appointed under Subsection (2)(b) shall:
(a) be knowledgeable regarding the health care system and the characteristics and use of health data;
(b) be selected so that the committee at all times includes individuals who provide care;
(c) include one person employed by or otherwise associated with a general acute hospital as defined by Section 26-21-2, who is knowledgeable about the collection, analysis, and use of health care data;
(d) include two physicians, as defined in Section 58-67-102:
(i) who are licensed to practice in this state;
(ii) who actively practice medicine in this state;
(iii) who are trained in or have experience with the collection, analysis, and use of health care data; and
(iv) one of whom is selected by the Utah Medical Association;
(e) include three persons:
(i) who are:
(A) employed by or otherwise associated with a business that supplies health care insurance to its employees; and
(B) knowledgeable about the collection and use of health care data; and
(ii) at least one of whom represents an employer employing 50 or fewer employees;
(f) include three persons representing health insurers:

(i) at least one of whom is employed by or associated with a third-party payor that is not licensed under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;
(ii) at least one of whom is employed by or associated with a third party payer that is licensed under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans; and
(iii) who are trained in, or experienced with the collection, analysis, and use of health care data;
(g) include two consumer representatives:
(i) from organized consumer or employee associations; and
(ii) knowledgeable about the collection and use of health care data;
(h) include one person:
(i) representative of a neutral, non-biased entity that can demonstrate that it has the broad support of health care payers and health care providers; and
(ii) who is knowledgeable about the collection, analysis, and use of health care data; and
(i) include two persons representing public health who are trained in, or experienced with the collection, use, and analysis of health care data.

(4)
(a) Except as required by Subsection (4)(b), as terms of current committee members expire, the governor shall appoint each new member or reappointed member to a four-year term.
(b) Notwithstanding the requirements of Subsection (4)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years.
(c) Members may serve after their terms expire until replaced.

(5) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(6) Committee members shall annually elect a chair of the committee from among their membership. The chair shall report to the executive director.

(7) The committee shall meet at least once during each calendar quarter. Meeting dates shall be set by the chair upon 10 working days notice to the other members, or upon written request by at least four committee members with at least 10 working days notice to other committee members.

(8) Eight committee members constitute a quorum for the transaction of business. Action may not be taken except upon the affirmative vote of a majority of a quorum of the committee.

(9) 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.

(10) All meetings of the committee shall be open to the public, except that the committee may hold a closed meeting if the requirements of Sections 52-4-204, 52-4-205, and 52-4-206 are met.

Amended by Chapter 118, 2014 General Session

26-33a-104 Purpose, powers, and duties of the committee.

(1) The purpose of the committee is to direct a statewide effort to collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care and also to facilitate interaction among those with concern for health care issues.

(2) The committee shall:
(a) with the concurrence of the department and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, develop and adopt by rule, following public hearing and comment, a health data plan that shall among its elements:
(i) identify the key health care issues, questions, and problems amenable to resolution or improvement through better data, more extensive or careful analysis, or improved dissemination of health data;
(ii) document existing health data activities in the state to collect, organize, or make available types of data pertinent to the needs identified in Subsection (2)(a)(i);
(iii) describe and prioritize the actions suitable for the committee to take in response to the needs identified in Subsection (2)(a)(i) in order to obtain or to facilitate the obtaining of needed data, and to encourage improvements in existing data collection, interpretation, and reporting activities, and indicate how those actions relate to the activities identified under Subsection (2)(a)(ii);
(iv) detail the types of data needed for the committee's work, the intended data suppliers, and the form in which such data are to be supplied, noting the consideration given to the potential alternative sources and forms of such data and to the estimated cost to the individual suppliers as well as to the department of acquiring these data in the proposed manner; the plan shall reasonably demonstrate that the committee has attempted to maximize cost-effectiveness in the data acquisition approaches selected;
(v) describe the types and methods of validation to be performed to assure data validity and reliability;
(vi) explain the intended uses of and expected benefits to be derived from the data specified in Subsection (2)(a)(iv), including the contemplated tabulation formats and analysis methods; the benefits described shall demonstrably relate to one or more of the following:
(A) promoting quality health care;
(B) managing health care costs; or
(C) improving access to health care services;
(vii) describe the expected processes for interpretation and analysis of the data flowing to the committee; noting specifically the types of expertise and participation to be sought in those processes; and
(viii) describe the types of reports to be made available by the committee and the intended audiences and uses;
(b) have the authority to collect, validate, analyze, and present health data in accordance with the plan while protecting individual privacy through the use of a control number as the health data identifier;
(c) evaluate existing identification coding methods and, if necessary, require by rule adopted in accordance with Subsection (3), that health data suppliers use a uniform system for identification of patients, health care facilities, and health care providers on health data they submit under this chapter; and
(d) advise, consult, contract, and cooperate with any corporation, association, or other entity for the collection, analysis, processing, or reporting of health data identified by control number only in accordance with the plan.
(3) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the committee , with the concurrence of the department, may adopt rules to carry out the provisions of this chapter.
(4) Except for data collection, analysis, and validation functions described in this section, nothing in this chapter shall be construed to authorize or permit the committee to perform regulatory

functions which are delegated by law to other agencies of the state or federal governments or to perform quality assurance or medical record audit functions that health care facilities, health care providers, or third party payors are required to conduct to comply with federal or state law. The committee may not recommend or determine whether a health care provider, health care facility, third party payor, or self-funded employer is in compliance with federal or state laws including federal or state licensure, insurance, reimbursement, tax, malpractice, or quality assurance statutes or common law.

(5) Nothing in this chapter shall be construed to require a data supplier to supply health data identifying a patient by name or describing detail on a patient beyond that needed to achieve the approved purposes included in the plan.

(6) No request for health data shall be made of health care providers and other data suppliers until a plan for the use of such health data has been adopted.

(7) If a proposed request for health data imposes unreasonable costs on a data supplier, due consideration shall be given by the committee to altering the request. If the request is not altered, the committee shall pay the costs incurred by the data supplier associated with satisfying the request that are demonstrated by the data supplier to be unreasonable.

(8) After a plan is adopted as provided in Section 26-33a-106.1, the committee may require any data supplier to submit fee schedules, maximum allowable costs, area prevailing costs, terms of contracts, discounts, fixed reimbursement arrangements, capitations, or other specific arrangements for reimbursement to a health care provider.

(9) The committee may not publish any health data collected under Subsection (8) that would disclose specific terms of contracts, discounts, or fixed reimbursement arrangements, or other specific reimbursement arrangements between an individual provider and a specific payer.

(10) Nothing in Subsection (8) shall prevent the committee from requiring the submission of health data on the reimbursements actually made to health care providers from any source of payment, including consumers.

Amended by Chapter 74, 2016 General Session

26-33a-105 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;

(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.

Enacted by Chapter 305, 1990 General Session

26-33a-106 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.

Amended by Chapter 201, 1996 General Session

26-33a-106.1 Health care cost and reimbursement data.

(1) The committee shall, as funding is available:

(a) establish a plan for collecting data from data suppliers, as defined in Section 26-33a-102, 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; and

(f) share data collected under this chapter with the state auditor for use in the health care price transparency tool described in Section 67-3-11.

(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 shall not be liable for a breach of or unlawful disclosure of the data obtained by an entity described in Subsection (1)(b).

(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.

Amended by Chapter 370, 2019 General Session

26-33a-106.5 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 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 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 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the committee , with the concurrence of the department, shall adopt by rule 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;

(ii) may use a private, independent analyst under Subsection (3)(a) in preparing the report required by this section; and

(iii) shall identify and report to the Legislature's Health and Human Services Interim Committee by July 1, 2014, and every July 1 thereafter until July 1, 2019, at least three new measures of quality to be added to the report each year.

(d) A report published by the department under this Subsection (6):

(i) is subject to the requirements of Section 26-33a-107; 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).

Amended by Chapter 370, 2019 General Session

26-33a-107 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, 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.

Amended by Chapter 74, 2016 General Session

26-33a-108 Disclosure of identifiable health data prohibited.

(1) All information, reports, statements, memoranda, or other data received by the committee are strictly confidential. 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 and 26-33a-109.
(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.

Amended by Chapter 201, 1996 General Session

26-33a-109 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; or
  (b) the disclosure complies with the provisions of:
    (i) this section;
    (ii) insurance enrollment and coordination of benefits under Subsection 26-33a-106.1(1)(d); or
    (iii) risk adjusting under Subsection 26-33a-106.1(1)(b).
(2) 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 and statistical work from an institutional review board; and
  (b) whether the requesting entity complies with the provisions of Subsection (3).
(3) 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 and 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 and 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 or other applicable law.
(4) A person accessing identifiable health data pursuant to Subsection (3) 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.

Amended by Chapter 74, 2016 General Session

26-33a-110 Penalties.

(1) Any use, release, or publication of health care data contrary to the provisions of Sections 26-33a-108 and 26-33a-109 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.

Enacted by Chapter 305, 1990 General Session

26-33a-111 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 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 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.

Amended by Chapter 297, 2011 General Session

26-33a-115 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.

Enacted by Chapter 102, 2013 General Session

26-33a-116 Health care billing data.
(1) Subject to Subsection (2), the department shall make aggregate data produced under this chapter 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.
(b) The department may not release any data under Subsection (1) that may be identifiable health data of a patient.

Enacted by Chapter 287, 2019 General Session

Chapter 34
Uniform Determination of Death Act

26-34-1 Short title.
This act is known as the "Uniform Determination of Death Act."

Enacted by Chapter 276, 1989 General Session

26-34-2 Definition of death -- Determination of death.
(1) An individual is dead if the individual has sustained either:
(a) irreversible cessation of circulatory and respiratory functions; or
(b) irreversible cessation of all functions of the entire brain, including the brain stem.
(2) A determination of death shall be made in accordance with accepted medical standards.

Amended by Chapter 297, 2011 General Session

Chapter 35a
Nursing Care Facility Assessment Act

26-35a-101 Title.
This chapter is known as the "Nursing Care Facility Assessment Act."

Enacted by Chapter 284, 2004 General Session

26-35a-102 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.

Amended by Chapter 366, 2011 General Session

26-35a-103 Definitions.

As used in this chapter:

(1)

(a) "Nursing care facility" means:

(i) a nursing care facility described in Subsection 26-21-2(17);

(ii) beginning January 1, 2006, a designated swing bed in:

(A) a general acute hospital as defined in Subsection 26-21-2(11); 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.

(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 defined in Section 26-21-2; 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.

Amended by Chapter 39, 2018 General Session

26-35a-104 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 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, 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 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 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, or that fails to file a return as required by this chapter, shall pay, in addition to the assessment, penalties and interest as provided in Section 26-35a-105.

Amended by Chapter 443, 2017 General Session

26-35a-105 Penalties and interest.

(1) The penalty for failure to file a return or pay the assessment due within the time prescribed by this chapter 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 or an unpaid penalty under this chapter is 12% annually.

(6) The department may waive the imposition of a penalty for good cause.

Enacted by Chapter 284, 2004 General Session

26-35a-106 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).

Amended by Chapter 443, 2017 General Session

26-35a-107 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.

Amended by Chapter 443, 2017 General Session

26-35a-108 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, 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.

Amended by Chapter 366, 2011 General Session

Chapter 36b
Inpatient Hospital Assessment Act

Part 1
General Provisions

26-36b-101 Title.
This chapter is known as "Inpatient Hospital Assessment Act."

Enacted by Chapter 279, 2016 General Session

26-36b-102 Application.
(1) Other than for the imposition of the assessment described in this chapter, nothing in this chapter 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 may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.
(3) This chapter 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.

Amended by Chapter 384, 2018 General Session

26-36b-103 Definitions.
As used in this chapter:
(1) "Assessment" means the inpatient hospital assessment established by this chapter.
(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.

Amended by Chapter 1, 2019 General Session

Part 2
Assessment and Collection

26-36b-201 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;
(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 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-202 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, 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;
(b) audit records of a facility that:
(i) is subject to the assessment imposed by this chapter; 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 separately from the assessment in Chapter 36d, Hospital Provider Assessment Act; and
(b) deposit assessments collected under this chapter into the Medicaid Expansion Fund created by Section 26-36b-208.

Amended by Chapter 393, 2019 General Session

26-36b-203 Quarterly notice.
(1) Quarterly assessments imposed by this chapter 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-204 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 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) The department shall, on or before October 15, 2017, and on or before October 15 of each subsequent year, produce a report that calculates 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-205 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 Subsection 26-36b-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, 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.
(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.
(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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-206 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.
(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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-207 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, within the time required by this chapter, 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-208 Medicaid Expansion Fund.
(1) There is created an expendable special revenue fund known as the Medicaid Expansion Fund.
(2) The fund consists of:
  (a) assessments collected under this chapter;
  (b) intergovernmental transfers under Section 26-36b-206;

(c) savings attributable to the health coverage improvement program as determined by the department;
(d) savings attributable to the enhancement waiver program as determined by the department;
(e) savings attributable to the Medicaid waiver expansion as determined by the department;
(f) savings attributable to the inclusion of psychotropic drugs on the preferred drug list under Subsection 26-18-2.4(3) as determined by the department;
(g) revenues collected from the sales tax described in Subsection 59-12-103(13);
(h) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;
(i) interest earned on money in the fund; and
(j) additional amounts as appropriated by the Legislature.

(3)
(a) The fund shall earn interest.
(b) All interest earned on fund money shall be deposited into the fund.

(4)
(a) A state agency administering the provisions of this chapter may use money from the fund to pay the costs, not otherwise paid for with federal funds or other revenue sources, of:
(i) the health coverage improvement program;
(ii) the enhancement waiver program;
(iii) a Medicaid waiver expansion; and
(iv) the outpatient upper payment limit supplemental payments under Section 26-36b-210.
(b) A state agency administering the provisions of this chapter may not use:
(i) funds described in Subsection (2)(b) to pay the cost of private outpatient upper payment limit supplemental payments; or
(ii) money in the fund for any purpose not described in Subsection (4)(a).

Amended by Chapter 1, 2019 General Session
Amended by Chapter 393, 2019 General Session

26-36b-209 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-210 Outpatient upper payment limit supplemental payments.

(1) Beginning on the effective date of the assessment imposed under this chapter, 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

26-36b-211 Repeal of assessment.
(1) The assessment imposed by this chapter 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 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; 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 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;
  (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 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.

Amended by Chapter 384, 2018 General Session
Amended by Chapter 468, 2018 General Session

Chapter 36c
Medicaid Expansion Hospital Assessment Act

Part 1
General Provisions

26-36c-101 Title.
This chapter is known as the "Medicaid Expansion Hospital Assessment Act."

Enacted by Chapter 468, 2018 General Session

26-36c-102 Definitions.
As used in this chapter:
(1) "Assessment" means the Medicaid expansion hospital assessment established by this chapter.
(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.

Amended by Chapter 1, 2019 General Session

26-36c-103 Application.
(1) Other than for the imposition of the assessment described in this chapter, nothing in this chapter 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 may include the assessment as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.
(3) This chapter 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.

Enacted by Chapter 468, 2018 General Session

Part 2
Assessment and Collection

26-36c-201 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;
(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 is due and payable in accordance with Subsection 26-36c-202(4).

Amended by Chapter 1, 2019 General Session

26-36c-202 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, 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;

(b) audit records of a facility that:

(i) is subject to the assessment imposed under this chapter; 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 into the Medicaid Expansion Fund.

(4)

(a) Hospitals shall pay the quarterly assessments imposed by this chapter 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.

Amended by Chapter 393, 2019 General Session

26-36c-203 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.

Amended by Chapter 1, 2019 General Session

26-36c-204 Hospital financing.

(1) Private hospitals shall be assessed under this chapter for the portion of the hospital share described in Section 26-36c-209.
(2) The department shall, on or before October 15, 2020, and on or before October 15 of each subsequent year, produce a report that calculates 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.

Amended by Chapter 1, 2019 General Session

26-36c-205 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.
(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.
(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.

Amended by Chapter 136, 2019 General Session

26-36c-206 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.
(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.

Amended by Chapter 1, 2019 General Session

26-36c-207 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, within the time required by this chapter, 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.

Enacted by Chapter 468, 2018 General Session

26-36c-208 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.

Amended by Chapter 1, 2019 General Session

26-36c-209 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 for 69% of the hospital share;
(b) require the state teaching hospital to make an intergovernmental transfer under this chapter for 30% of the hospital share; and
(c) require non-state government hospitals to make an intergovernmental transfer under this chapter 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.

Amended by Chapter 1, 2019 General Session

26-36c-210 Suspension of assessment.
(1) The department shall suspend the assessment imposed by this chapter when the executive director certifies that:
(a) action by Congress is in effect that disqualifies the assessment imposed by this chapter 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; 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;

(b) the division shall disburse money in the Medicaid Expansion Fund that was derived from assessments imposed by this chapter 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 to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years.

Amended by Chapter 136, 2019 General Session

Chapter 36d
Hospital Provider Assessment Act

Part 1
General Provisions

26-36d-101 Title.

This chapter is known as the "Hospital Provider Assessment Act."

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-102 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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-103 Definitions.

As used in this chapter:

(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.
(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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

Part 2
Hospital Provider Assessment

26-36d-201 Application of chapter.
(1) Other than for the imposition of the assessment described in this chapter, nothing in this chapter 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 may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This chapter 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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-202 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 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, 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; and
(B) does not file a Medicare Cost Report.
(c) The department shall forward proceeds from the assessment imposed by this chapter 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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-203 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.

(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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-204 Quarterly notice -- Collection.

Quarterly assessments imposed by this chapter shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-205 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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-206 Penalties and interest.

(1) A facility that fails to pay any assessment or file a return as required under this chapter, within the time required by this chapter, 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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-207 Hospital Provider Assessment Expendable Revenue Fund.

(1) There is created an expendable special revenue fund known as the "Hospital Provider Assessment Expendable Revenue Fund."
(2) The fund shall consist of:
  (a) the assessments collected by the department under this chapter;
  (b) any interest and penalties levied with the administration of this chapter; and
  (c) any other funds received as donations for the fund and appropriations from other sources.
(3) Money in the fund shall be used:
  (a) to support capitated rates consistent with Subsection 26-36d-203(1)(d) for accountable care organizations; and
  (b) to reimburse money collected by the division from a hospital through a mistake made under this chapter.

Repealed and Re-enacted by Chapter 455, 2019 General Session

26-36d-208 Repeal of assessment.

(1) The repeal of the assessment imposed by this chapter 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 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;
(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 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, 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.

Repealed and Re-enacted by Chapter 455, 2019 General Session

Chapter 37a
Ambulance Service Provider Assessment

Part 1
General Provisions

26-37a-101 Title.
This chapter is known as "Ambulance Service Provider Assessment."

Enacted by Chapter 440, 2015 General Session

26-37a-102 Definitions.
As used in this chapter:
(1) "Ambulance service provider" means:

(a) an ambulance provider as defined in Section 26-8a-102; or
(b) a non-911 service provider as defined in Section 26-8a-102.
(2) "Assessment" means the Medicaid ambulance service provider assessment established by this chapter.
(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).

Amended by Chapter 348, 2016 General Session

26-37a-103 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;
(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; 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.

Enacted by Chapter 440, 2015 General Session

26-37a-104 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.

Enacted by Chapter 440, 2015 General Session

26-37a-105 Medicaid ambulance service provider adjustment under fee-for-service rates.

The division shall, if the assessment imposed by this chapter 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.

Enacted by Chapter 440, 2015 General Session

26-37a-106 Penalties.

The division shall require an ambulance service provider that fails to pay an assessment due under this chapter 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.

Enacted by Chapter 440, 2015 General Session

26-37a-107 Ambulance Service Provider Assessment Expendable Revenue Fund.

(1) There is created an expendable special revenue fund known as the "Ambulance Service Provider Assessment Expendable Revenue Fund."
(2) The fund shall consist of:
(a) the assessments collected by the division under this chapter;
(b) the penalties collected by the division under this chapter;
(c) donations to the fund; and
(d) appropriations by the Legislature.
(3) Money in the fund shall be used:
(a) to support fee-for-service rates; and
(b) to reimburse money to an ambulance service provider that is collected by the division from the ambulance service provider through a mistake made under this chapter.

Enacted by Chapter 440, 2015 General Session

26-37a-108 Repeal of assessment.

(1) This chapter 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 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.

(2) If this chapter 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, deposited before the determination made under Subsection (1), shall be disbursed under Section 26-37a-107 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.

Enacted by Chapter 440, 2015 General Session

Chapter 38
Utah Indoor Clean Air Act

26-38-1 Title.

This chapter is known as the "Utah Indoor Clean Air Act."

Enacted by Chapter 281, 1994 General Session

26-38-2 Definitions.

As used in this chapter:

(1) "E-cigarette":

(a) means any electronic oral device:

(i) that provides an aerosol or a vapor of nicotine or other substance; and

(ii) which simulates smoking through its use or through inhalation of the device; and

(b) includes an oral device that is:

(i) composed of a heating element, battery, or electronic circuit; and

(ii) marketed, manufactured, distributed, or sold as:

(A) an e-cigarette;

(B) e-cigar;

(C) e-pipe; or

(D) any other product name or descriptor, if the function of the product meets the definition of Subsection (1)(a).

(2) "Non-tobacco shisha" means any product that:

(a) does not contain tobacco or nicotine; and

(b) is smoked or intended to be smoked in a hookah or water pipe.

(3) "Place of public access" means any enclosed indoor place of business, commerce, banking, financial service, or other service-related activity, whether publicly or privately owned and whether operated for profit or not, to which persons not employed at the place of public access have general and regular access or which the public uses, including:

(a) buildings, offices, shops, elevators, or restrooms;

(b) means of transportation or common carrier waiting rooms;

(c) restaurants, cafes, or cafeterias;

(d) taverns as defined in Section 32B-1-102, or cabarets;

(e) shopping malls, retail stores, grocery stores, or arcades;
(f) libraries, theaters, concert halls, museums, art galleries, planetariums, historical sites, auditoriums, or arenas;
(g) barber shops, hair salons, or laundromats;
(h) sports or fitness facilities;
(i) common areas of nursing homes, hospitals, resorts, hotels, motels, "bed and breakfast" lodging facilities, and other similar lodging facilities, including the lobbies, hallways, elevators, restaurants, cafeterias, other designated dining areas, and restrooms of any of these;
(j)
(i) any child care facility or program subject to licensure or certification under this title, including those operated in private homes, when any child cared for under that license is present; and
(ii) any child care, other than child care as defined in Section 26-39-102, that is not subject to licensure or certification under this title, when any child cared for by the provider, other than the child of the provider, is present;
(k) public or private elementary or secondary school buildings and educational facilities or the property on which those facilities are located;
(l) any building owned, rented, leased, or otherwise operated by a social, fraternal, or religious organization when used solely by the organization members or their guests or families;
(m) any facility rented or leased for private functions from which the general public is excluded and arrangements for the function are under the control of the function sponsor;
(n) any workplace that is not a place of public access or a publicly owned building or office but has one or more employees who are not owner-operators of the business;
(o) any area where the proprietor or manager of the area has posted a conspicuous sign stating "no smoking", "thank you for not smoking", or similar statement; and
(p) a holder of a bar establishment license, as defined in Section 32B-1-102.
(4) "Publicly owned building or office" means any enclosed indoor place or portion of a place owned, leased, or rented by any state, county, or municipal government, or by any agency supported by appropriation of, or by contracts or grants from, funds derived from the collection of federal, state, county, or municipal taxes.
(5) "Shisha" means any product that:
(a) contains tobacco or nicotine; and
(b) is smoked or intended to be smoked in a hookah or water pipe.
(6) "Smoking" means:
(a) the possession of any lighted or heated tobacco product in any form;
(b) inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, pipe, or hookah that contains:
(i) tobacco or any plant product intended for inhalation;
(ii) shisha or non-tobacco shisha;
(iii) nicotine;
(iv) a natural or synthetic tobacco substitute; or
(v) a natural or synthetic flavored tobacco product;
(c) using an e-cigarette; or
(d) using an oral smoking device intended to circumvent the prohibition of smoking in this chapter.

Amended by Chapter 231, 2018 General Session
Amended by Chapter 281, 2018 General Session

26-38-3 Restriction on smoking in public places and in specified places -- Exceptions.

(1) Except as provided in Subsection (2), smoking is prohibited in all enclosed indoor places of public access and publicly owned buildings and offices.

(2) Subsection (1) does not apply to:

(a) areas not commonly open to the public of owner-operated businesses having no employees other than the owner-operator;

(b) guest rooms in hotels, motels, "bed and breakfast" lodging facilities, and other similar lodging facilities, but smoking is prohibited under Subsection (1) in the common areas of these facilities, including dining areas and lobby areas; and

(c) separate enclosed smoking areas:

(i) located in the passenger terminals of an international airport located in the city of the first class;

(ii) vented directly to the outdoors; and

(iii) certified, by a heating, ventilation, and air conditioning engineer licensed by the state, to prevent the drift of any smoke to any nonsmoking area of the terminal.

Amended by Chapter 383, 2009 General Session

26-38-3.5 Smoking ban exemption for Native American ceremony.

(1) A person is exempt from the restrictions of Section 26-38-3 if the person:

(a) is a member of an American Indian tribe whose members are recognized as eligible for the special programs and services provided by the United States to American Indians who are members of those tribes;

(b) is an American Indian who actively practices an American Indian religion, the origin and interpretation of which is from a traditional American Indian culture;

(c) is smoking tobacco using the traditional pipe of an American Indian tribal religious ceremony, of which tribe the person is a member, and is smoking the pipe as part of that ceremony; and

(d) the ceremony is conducted by a pipe carrier, Indian spiritual person, or medicine person recognized by the tribe of which the person is a member and the Indian community.

(2) This section takes precedence over Section 26-38-3.

(3) A religious ceremony using a traditional pipe under this section is subject to any applicable state or local law, except as provided in this section.

Enacted by Chapter 125, 1995 General Session

26-38-6 Local ordinances.

(1) This chapter supersedes any ordinance enacted by the governing body of a political subdivision that restricts smoking in a place of public access as defined in Section 26-38-2 and that is not essentially identical to the provisions of this chapter.

(2) This chapter does not supersede an ordinance enacted by the governing body of a political subdivision that restricts smoking in outdoor places of public access which are owned or operated by:

(a) a political subdivision as defined in Section 17B-1-102;

(b) a state institution of higher education; or

(c) a state institution of public education.

Amended by Chapter 44, 2007 General Session

26-38-7 Enforcement action by proprietors.
(1) An owner or the agent or employee of the owner of a place where smoking is prohibited under Subsection 26-38-3(1) who observes a person smoking in apparent violation of this chapter shall request the person to stop smoking.
(2) If the person fails to comply, the proprietor or the agent or employee of the proprietor shall ask the person to leave the premises.

Amended by Chapter 171, 2012 General Session

26-38-8 Penalties.
(1) A first violation of Section 26-38-3 is subject to a civil penalty of not more than $100.
(2) Any second or subsequent violation of Section 26-38-3 is subject to a civil penalty of not less than $100 and not more than $500.

Amended by Chapter 218, 2010 General Session

26-38-9 Enforcement of chapter.
(1) The state Department of Health and local health departments shall:
  (a) enforce this chapter and shall coordinate their efforts to promote the most effective enforcement of this chapter; and
  (b) impose the penalties under Section 26-38-8 in accordance with this section.
(2) When enforcing this chapter, the state Department of Health and the local health departments shall notify persons of alleged violations of this chapter, conduct hearings, and impose penalties in accordance with Title 63G, Chapter 4, Administrative Procedures Act.
(3) Civil penalties collected under this section by:
  (a) a local health department shall be paid to the treasurer of the county in which the violation was committed; and
  (b) the state Department of Health shall be deposited in the General Fund.

Amended by Chapter 382, 2008 General Session

Chapter 39
Utah Child Care Licensing Act

Part 1
General Provisions

26-39-101 Title.
This chapter is known as the "Utah Child Care Licensing Act."

Enacted by Chapter 196, 1997 General Session

26-39-102 Definitions.
As used in this chapter:
(1) "Advisory committee" means the Residential Child Care Licensing Advisory Committee, created in Section 26-1-7.

(2)
(a) "Center based child care" means, except as provided in Subsection (2)(b), a child care program licensed under this chapter.
(b) "Center based child care" does not include:
(i) a residential child care provider certified under Section 26-39-402; or
(ii) a facility or program exempt under Section 26-39-403.
(3) "Child care" means continuous care and supervision of five or more qualifying children, that is:
(a) in lieu of care ordinarily provided by a parent in the parent's home;
(b) for less than 24 hours a day; and
(c) for direct or indirect compensation.
(4) "Child care program" means a child care facility or program operated by a person who holds a license or certificate issued in accordance with this chapter.
(5) "Exempt provider" means a person who provides care described in Subsection 26-39-403(2).
(6) "Licensing committee" means the Child Care Center Licensing Committee created in Section 26-1-7.
(7) "Public school" means:
(a) a school, including a charter school, that:
(i) is directly funded at public expense; and
(ii) provides education to qualifying children for any grade from first grade through twelfth grade; or
(b) a school, including a charter school, that provides:
(i) preschool or kindergarten to qualifying children, regardless of whether the preschool or kindergarten is funded at public expense; and
(ii) education to qualifying children for any grade from first grade through twelfth grade, if each grade, from first grade to twelfth grade, that is provided at the school, is directly funded at public expense.
(8) "Qualifying child" means an individual who is:
(a)
(i) under the age of 13; or
(ii) under the age of 18, if the person has a disability; and
(b) a child of:
(i) a person other than the person providing care to the child;
(ii) a licensed or certified residential child care provider, if the child is under the age of four; or
(iii) an employee or owner of a licensed child care center, if the child is under the age of four.
(9) "Residential child care" means child care provided in the home of a provider.

Amended by Chapter 220, 2015 General Session

Part 2
Child Care Licensing Committees

26-39-200 Child Care Center Licensing Committee.
(1)
(a) The Child Care Center Licensing Committee created in Section 26-1-7 shall be comprised of seven members appointed by the governor and approved by the Senate in accordance with this subsection.

(b) The governor shall appoint three members who:
(i) have at least five years of experience as an owner in or director of a for profit or not-for-profit center based child care; and
(ii) hold an active license as a child care center from the department to provide center based child care.
(c)
(i) The governor shall appoint one member to represent each of the following:
(A) a parent with a child in center based child care;
(B) a child development expert from the state system of higher education;
(C) except as provided in Subsection (1)(e), a pediatrician licensed in the state; and
(D) an architect licensed in the state.
(ii) Except as provided in Subsection (1)(c)(i)(B), a member appointed under Subsection (1)(c)(i) may not be an employee of the state or a political subdivision of the state.
(d) At least one member described in Subsection (1)(b) shall at the time of appointment reside in a county that is not a county of the first class.
(e) For the appointment described in Subsection (1)(c)(i)(C), the governor may appoint a health care professional who specializes in pediatric health if:
(i) the health care professional is licensed under:
(A)Title 58, Chapter 31b, Nurse Practice Act, as an advanced practice nurse practitioner; or
(B)Title 58, Chapter 70a, Utah Physician Assistant Act; and
(ii) before appointing a health care professional under this Subsection (1)(e), the governor:
(A) sends a notice to a professional physician organization in the state regarding the opening for the appointment described in Subsection (1)(c)(i)(C); and
(B) receives no applications from a pediatrician who is licensed in the state for the appointment described in Subsection (1)(c)(i)(C) within 90 days after the day on which the governor sends the notice described in Subsection (1)(e)(ii)(A).

(2)
(a) Except as required by Subsection (2)(b), as terms of current members expire, the governor shall appoint each new member or reappointed member to a four-year term ending June 30.
(b) Notwithstanding the requirements of Subsection (2)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of members are staggered so that approximately half of the licensing committee is appointed every two years.
(c) Upon the expiration of the term of a member of the licensing committee, the member shall continue to hold office until a successor is appointed and qualified.
(d) A member may not serve more than two consecutive terms.
(e) Members of the licensing committee shall annually select one member to serve as chair who shall establish the agenda for licensing committee meetings.

(3) When a vacancy occurs in the membership for any reason, the governor, with the consent of the Senate, shall appoint a replacement for the unexpired term.

(4)
(a) The licensing committee shall meet at least every two months.
(b) The director may call additional meetings:
(i) at the director's discretion;
(ii) upon the request of the chair; or
(iii) upon the written request of three or more members.

(5) Three members of the licensing committee constitute a quorum for the transaction of business.

Amended by Chapter 111, 2019 General Session

26-39-201 Residential Child Care Licensing Advisory Committee.

(1)
(a) The Residential Child Care Licensing Advisory Committee created in Section 26-1-7 shall advise the department on rules made by the department under this chapter for residential child care.
(b) The advisory committee shall be composed of the following nine members who shall be appointed by the executive director:
(i) two child care consumers;
(ii) three licensed residential child care providers;
(iii) one certified residential child care provider;
(iv) one individual with expertise in early childhood development; and
(v) two health care providers.

(2)
(a) Members of the advisory committee shall be appointed for four-year terms, except for those members who have been appointed to complete an unexpired term.
(b) Appointments and reappointments may be staggered so that 1/4 of the advisory committee changes each year.
(c) The advisory committee shall annually elect a chairman from its membership.

(3) The advisory committee shall meet at least quarterly, or more frequently as determined by the executive director, the chairman, or three or more members of the committee.

(4) Five members constitute a quorum and a vote of the majority of the members present constitutes an action of the advisory committee.

Amended by Chapter 322, 2014 General Session

26-39-202 Members serve without pay -- Reimbursement for expenses.

A member of the Residential Child Care Licensing Advisory Committee and the Child Care Center Licensing Committee may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses as allowed in:

(1) Section 63A-3-106;

(2) Section 63A-3-107; and

(3) rules made by the Division of Finance according to Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 322, 2014 General Session

26-39-203 Duties of the Child Care Center Licensing Committee.

(1) The licensing committee shall:
(a) in concurrence with the department and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules that govern center based child care as necessary to protect qualifying children's common needs for a safe and healthy environment, to provide for:
(i) adequate facilities and equipment; and
(ii) competent caregivers considering the age of the children and the type of program offered by the licensee;

(b) in concurrence with the department and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules necessary to carry out the purposes of this chapter that govern center based child care, in the following areas:
(i) requirements for applications, the application process, and compliance with other applicable statutes and rules;
(ii) documentation and policies and procedures that providers shall have in place in order to be licensed, in accordance with Subsection (1);
(iii) categories, classifications, and duration of initial and ongoing licenses;
(iv) changes of ownership or name, changes in licensure status, and changes in operational status;
(v) license expiration and renewal, contents, and posting requirements;
(vi) procedures for inspections, complaint resolution, disciplinary actions, and other procedural measures to encourage and assure compliance with statute and rule; and
(vii) guidelines necessary to assure consistency and appropriateness in the regulation and discipline of licensees;
(c) advise the department on the administration of a matter affecting center based child care;
(d) advise and assist the department in conducting center based child care provider seminars; and
(e) perform other duties as provided under Section 26-39-301.
(2)
(a) The licensing committee may not enforce the rules adopted under this section.
(b) The department shall enforce the rules adopted under this section in accordance with Section 26-39-301.

Amended by Chapter 74, 2016 General Session

Part 3
Department Duties

26-39-301 Duties of the department -- Enforcement of chapter -- Licensing committee requirements.
(1) With regard to residential child care licensed or certified under this chapter, the department may:
(a) make and enforce rules to implement this chapter and, as necessary to protect qualifying children's common needs for a safe and healthy environment, to provide for:
(i) adequate facilities and equipment; and
(ii) competent caregivers, considering the age of the children and the type of program offered by the licensee; and
(b) make and enforce rules necessary to carry out the purposes of this chapter, in the following areas:
(i) requirements for applications, the application process, and compliance with other applicable statutes and rules;
(ii) documentation and policies and procedures that providers shall have in place in order to be licensed, in accordance with Subsection (1)(a);
(iii) categories, classifications, and duration of initial and ongoing licenses;

(iv) changes of ownership or name, changes in licensure status, and changes in operational status;
(v) license expiration and renewal, contents, and posting requirements;
(vi) procedures for inspections, complaint resolution, disciplinary actions, and other procedural measures to encourage and assure compliance with statute and rule; and
(vii) guidelines necessary to assure consistency and appropriateness in the regulation and discipline of licensees.

(2) The department shall enforce the rules established by the licensing committee, with the concurrence of the department, for center based child care.

(3) Rules made under this chapter by the department, or the licensing committee with the concurrence of the department, shall be made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4)
(a) The licensing committee and the department may not regulate educational curricula, academic methods, or the educational philosophy or approach of the provider.
(b) The licensing committee and the department shall allow for a broad range of educational training and academic background in certification or qualification of child day care directors.

(5) In licensing and regulating child care programs, the licensing committee and the department shall reasonably balance the benefits and burdens of each regulation and, by rule, provide for a range of licensure, depending upon the needs and different levels and types of child care provided.

(6) Notwithstanding the definition of "qualifying child" in Section 26-39-102, the licensing committee and the department shall count children through age 12 and children with disabilities through age 18 toward the minimum square footage requirement for indoor and outdoor areas, including the child of:
(a) a licensed residential child care provider; or
(b) an owner or employee of a licensed child care center.

(7) Notwithstanding Subsection (1)(a)(i), the licensing committee and the department may not exclude floor space used for furniture, fixtures, or equipment from the minimum square footage requirement for indoor and outdoor areas if the furniture, fixture, or equipment is used:
(a) by qualifying children;
(b) for the care of qualifying children; or
(c) to store classroom materials.

(8)
(a) A child care center constructed prior to January 1, 2004, and licensed and operated as a child care center continuously since January 1, 2004, is exempt from the licensing committee's and the department's group size restrictions, if the child to caregiver ratios are maintained, and adequate square footage is maintained for specific classrooms.
(b) An exemption granted under Subsection (7)(a) is transferrable to subsequent licensed operators at the center if a licensed child care center is continuously maintained at the center.

(9) The licensing committee, with the concurrence of the department, shall develop, by rule, a five-year phased-in compliance schedule for playground equipment safety standards.

(10) The department shall set and collect licensing and other fees in accordance with Section 26-1-6.

(11) Nothing in this chapter may be interpreted to grant a municipality or county the authority to license or certify a child care program.

Amended by Chapter 58, 2018 General Session

Part 4
Licensing

26-39-401 Licensure requirements -- Expiration -- Renewal.

(1) Except as provided in Section 26-39-403, a person shall be licensed or certified in accordance with this chapter if the person:
  (a) provides or offers child care; or
  (b) provides care to qualifying children and requests to be licensed.
(2) The department may issue licenses for a period not exceeding 24 months to child care providers who meet the requirements of:
  (a) this chapter; and
  (b) the department's rules governing child care programs.
(3) A license issued under this chapter is not assignable or transferable.

Renumbered and Amended by Chapter 111, 2008 General Session

26-39-402 Residential child care certificate.

(1) A residential child care provider of five to eight qualifying children shall obtain a Residential Child Care Certificate from the department, unless Section 26-39-403 applies.
(2) The minimum qualifications for a Residential Child Care Certificate are:
  (a) the submission of:
    (i) an application in the form prescribed by the department;
    (ii) a certification and criminal background fee established in accordance with Section 26-1-6; and
    (iii) in accordance with Section 26-39-404, identifying information for each adult person and each juvenile age 12 through 17 years of age who resides in the provider's home:
      (A) for processing by the Department of Public Safety to determine whether any such person has been convicted of a crime;
      (B) to screen for a substantiated finding of child abuse or neglect by a juvenile court; and
      (C) to discover whether the person is listed in the Licensing Information System described in Section 62A-4a-1006;
  (b) an initial and annual inspection of the provider's home within 90 days of sending an intent to inspect notice to:
    (i) check the immunization record, as defined in Section 53G-9-301, of each qualifying child who receives child care in the provider's home;
    (ii) identify serious sanitation, fire, and health hazards to qualifying children; and
    (iii) make appropriate recommendations; and
  (c) annual training consisting of 10 hours of department-approved training as specified by the department by administrative rule, including a current department-approved CPR and first aid course.
(3) If a serious sanitation, fire, or health hazard has been found during an inspection conducted pursuant to Subsection (2)(b), the department shall require corrective action for the serious hazards found and make an unannounced follow up inspection to determine compliance.

(4) In addition to an inspection conducted pursuant to Subsection (2)(b), the department may inspect the home of a residential care provider of five to eight qualifying children in response to a complaint of:
(a) child abuse or neglect;
(b) serious health hazards in or around the provider's home; or
(c) providing residential child care without the appropriate certificate or license.
(5) Notwithstanding this section:
(a) a license under Section 26-39-401 is required of a residential child care provider who cares for nine or more qualifying children;
(b) a certified residential child care provider may not provide care to more than two qualifying children under the age of two; and
(c) an inspection may be required of a residential child care provider in connection with a federal child care program.
(6) With respect to residential child care, the department may only make and enforce rules necessary to implement this section.

Amended by Chapter 415, 2018 General Session
Amended by Chapter 344, 2017 General Session

26-39-403 Exclusions from chapter -- Criminal background checks by an excluded person.
(1) The provisions and requirements of this chapter do not apply to:
(a) a facility or program owned or operated by an agency of the United States government;
(b) group counseling provided by a mental health therapist, as defined in Section 58-60-102, who is licensed to practice in this state;
(c) a health care facility licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;
(d) care provided to a qualifying child by or in the home of a parent, legal guardian, grandparent, brother, sister, uncle, or aunt;
(e) care provided to a qualifying child, in the home of the provider, for less than four hours a day or on a sporadic basis, unless that child care directly affects or is related to a business licensed in this state; or
(f) care provided at a residential support program that is licensed by the Department of Human Services.
(2) The licensing and certification requirements of this chapter do not apply to:
(a) care provided to a qualifying child as part of a course of study at or a program administered by an educational institution that is regulated by the boards of education of this state, a private education institution that provides education in lieu of that provided by the public education system, or by a parochial education institution;
(b) care provided to a qualifying child by a public or private institution of higher education, if the care is provided in connection with a course of study or program, relating to the education or study of children, that is provided to students of the institution of higher education;
(c) care provided to a qualifying child at a public school by an organization other than the public school, if:
(i) the care is provided under contract with the public school or on school property; or
(ii) the public school accepts responsibility and oversight for the care provided by the organization;
(d) care provided to a qualifying child as part of a summer camp that operates on federal land pursuant to a federal permit;

(e) care provided by an organization that:
(i) qualifies for tax exempt status under Section 501(c)(3) of the Internal Revenue Code;
(ii) provides care pursuant to a written agreement with:
(A) a municipality, as defined in Section 10-1-104, that provides oversight for the program; or
(B) a county that provides oversight for the program; and
(iii) provides care to a child who is over the age of four and under the age of 13; or
(f) care provided to a qualifying child at a facility where:
(i) the parent or guardian of the qualifying child is at all times physically present in the building where the care is provided and the parent or guardian is near enough to reach the child within five minutes if needed;
(ii) the duration of the care is less than four hours for an individual qualifying child in any one day;
(iii) the care is provided on a sporadic basis;
(iv) the care does not include diapering a qualifying child; and
(v) the care does not include preparing or serving meals to a qualifying child.
(3) An exempt provider shall submit to the department:
(a) the information required under Subsections 26-39-404(1) and (2); and
(b) of the children receiving care from the exempt provider:
(i) the number of children who are less than two years old;
(ii) the number of children who are at least two years old and less than five years old; and
(iii) the number of children who are five years old or older.
(4) An exempt provider shall post, in a conspicuous location near the entrance of the exempt provider's facility, a notice prepared by the department that:
(a) states that the facility is exempt from licensure and certification; and
(b) provides the department's contact information for submitting a complaint.
(5) The department may not release the information it collects under Subsection (3) except in an aggregate count of children receiving care from exempt providers, without identifying a specific provider.

Amended by Chapter 366, 2017 General Session

26-39-404 Disqualified individuals -- Criminal history checks -- Payment of costs.
(1)
(a) Each exempt provider, except as provided in Subsection (1)(c), and each person requesting a residential certificate or to be licensed or to renew a license under this chapter shall submit to the department the name and other identifying information, which shall include fingerprints, of existing, new, and proposed:
(i) owners;
(ii) directors;
(iii) members of the governing body;
(iv) employees;
(v) providers of care;
(vi) volunteers, except parents of children enrolled in the programs; and
(vii) all adults residing in a residence where child care is provided.
(b)
(i) The Utah Division of Criminal Investigation and Technical Services within the Department of Public Safety shall process the information required under Subsection (1)(a) to determine whether the individual has been convicted of any crime.

(ii) The Utah Division of Criminal Investigation and Technical Services shall submit fingerprints required under Subsection (1)(a) to the FBI for a national criminal history record check.

(iii) A person required to submit information to the department under Subsection (1) shall pay the cost of conducting the record check described in this Subsection (1)(b).

(c) An exempt provider who provides care to a qualifying child as part of a program administered by an educational institution that is regulated by the State Board of Education is not subject to this Subsection (1), unless required by the Child Care and Development Block Grant, 42 U.S.C. Secs. 9857-9858r.

(2)

(a) Each person requesting a residential certificate or to be licensed or to renew a license under this chapter shall submit to the department the name and other identifying information of any person age 12 through 17 who resides in the residence where the child care is provided. The identifying information required for a person age 12 through 17 does not include fingerprints.

(b) The department shall access the juvenile court records to determine whether a person described in Subsection (1) or (2)(a) has been adjudicated in juvenile court of committing an act which if committed by an adult would be a felony or misdemeanor if:

(i) the person described in Subsection (1) is under the age of 28; or

(ii) the person described in Subsection (1) is:

(A) over the age of 28; and

(B) has been convicted, has pleaded no contest, or is currently subject to a plea in abeyance or diversion agreement for a felony or misdemeanor.

(3) Except as provided in Subsections (4) and (5), a licensee under this chapter or an exempt provider may not permit a person who has been convicted, has pleaded no contest, or is currently subject to a plea in abeyance or diversion agreement for any felony or misdemeanor, or if the provisions of Subsection (2)(b) apply, who has been adjudicated in juvenile court of committing an act which if committed by an adult would be a felony or a misdemeanor, to:

(a) provide child care;

(b) provide volunteer services for a child care program or an exempt provider;

(c) reside at the premises where child care is provided; or

(d) function as an owner, director, or member of the governing body of a child care program or an exempt provider.

(4)

(a) The department may, by rule, exempt the following from the restrictions of Subsection (3):

(i) specific misdemeanors; and

(ii) specific acts adjudicated in juvenile court, which if committed by an adult would be misdemeanors.

(b) In accordance with criteria established by rule, the executive director may consider and exempt individual cases not otherwise exempt under Subsection (4)(a) from the restrictions of Subsection (3).

(5) The restrictions of Subsection (3) do not apply to the following:

(a) a conviction or plea of no contest to any nonviolent drug offense that occurred on a date 10 years or more before the date of the criminal history check described in this section; or

(b) if the provisions of Subsection (2)(b) apply, any nonviolent drug offense adjudicated in juvenile court on a date 10 years or more before the date of the criminal history check described in this section.

Amended by Chapter 160, 2019 General Session

Part 5
Investigations and Records

26-39-501 Investigations -- Records.

(1) The department may conduct investigations necessary to enforce the provisions of this chapter.

(2) For purposes of this section:

(a) "Anonymous complainant" means a complainant for whom the department does not have the minimum personal identifying information necessary, including the complainant's full name, to attempt to communicate with the complainant after a complaint has been made.

(b) "Confidential complainant" means a complainant for whom the department has the minimum personal identifying information necessary, including the complainant's full name, to attempt to communicate with the complainant after a complaint has been made, but who elects under Subsection (3)(c) not to be identified to the subject of the complaint.

(c) "Subject of the complaint" means the licensee or certificate holder about whom the complainant is informing the department.

(3)

(a) If the department receives a complaint about a child care program or an exempt provider, the department shall:

(i) solicit information from the complainant to determine whether the complaint suggests actions or conditions that could pose a serious risk to the safety or well-being of a qualifying child;

(ii) as necessary:

(A) encourage the complainant to disclose the minimum personal identifying information necessary, including the complainant's full name, for the department to attempt to subsequently communicate with the complainant;

(B) inform the complainant that the department may not investigate an anonymous complaint;

(C) inform the complainant that the identity of a confidential complainant may be withheld from the subject of a complaint only as provided in Subsection (3)(c)(ii); and

(D) inform the complainant that the department may be limited in its use of information provided by a confidential complainant, as provided in Subsection (3)(c)(ii)(B); and

(iii) inform the complainant that a person is guilty of a class B misdemeanor under Section 76-8-506 if the person gives false information to the department with the purpose of inducing a change in that person's or another person's licensing or certification status.

(b) If the complainant elects to be an anonymous complainant, or if the complaint concerns events which occurred more than six weeks before the complainant contacted the department:

(i) shall refer the information in the complaint to the Division of Child and Family Services within the Department of Human Services, law enforcement, or any other appropriate agency, if the complaint suggests actions or conditions which could pose a serious risk to the safety or well-being of a child;

(ii) may not investigate or substantiate the complaint; and

(iii) may, during a regularly scheduled annual survey, inform the exempt provider, licensee, or certificate holder that is the subject of the complaint of allegations or concerns raised by:

(A) the anonymous complainant; or

(B) the complainant who reported events more than six weeks after the events occurred.

(c)

(i) If the complainant elects to be a confidential complainant, the department shall determine whether the complainant wishes to remain confidential:
(A) only until the investigation of the complaint has been completed; or
(B) indefinitely.
(ii)
(A) If the complainant elects to remain confidential only until the investigation of the complaint has been completed, the department shall disclose the name of the complainant to the subject of the complaint at the completion of the investigation, but no sooner.
(B) If the complainant elects to remain confidential indefinitely, the department:
(I) notwithstanding Subsection 63G-2-201(5)(b), may not disclose the name of the complainant, including to the subject of the complaint; and
(II) may not use information provided by the complainant to substantiate an alleged violation of state law or department rule unless the department independently corroborates the information.

(4)
(a) Prior to conducting an investigation of a child care program or an exempt provider in response to a complaint, a department investigator shall review the complaint with the investigator's supervisor.
(b) The investigator may proceed with the investigation only if:
(i) the supervisor determines the complaint is credible;
(ii) the complaint is not from an anonymous complainant; and
(iii) prior to the investigation, the investigator informs the subject of the complaint of:
(A) except as provided in Subsection (3)(c), the name of the complainant; and
(B) except as provided in Subsection (4)(c), the substance of the complaint.
(c) An investigator is not required to inform the subject of a complaint of the substance of the complaint prior to an investigation if doing so would jeopardize the investigation. However, the investigator shall inform the subject of the complaint of the substance of the complaint as soon as doing so will no longer jeopardize the investigation.

(5) If the department is unable to substantiate a complaint, any record related to the complaint or the investigation of the complaint:
(a) shall be classified under Title 63G, Chapter 2, Government Records Access and Management Act, as:
(i) a private or controlled record if appropriate under Section 63G-2-302 or 63G-2-304; or
(ii) a protected record under Section 63G-2-305; and
(b) if disclosed in accordance with Subsection 63G-2-201(5)(b), may not identify an individual child care program, exempt provider, licensee, certificate holder, or complainant.

(6) Any record of the department related to a complaint by an anonymous complainant is a protected record under Title 63G, Chapter 2, Government Records Access and Management Act, and, notwithstanding Subsection 63G-2-201(5)(b), may not be disclosed in a manner that identifies an individual child care program, exempt provider, licensee, certificate holder, or complainant.

Amended by Chapter 220, 2015 General Session

Part 6
Penalties

26-39-601 License violations -- Penalties.

(1) The department may deny or revoke a license and otherwise invoke disciplinary penalties if it finds:
  (a) evidence of committing or of aiding, abetting, or permitting the commission of any illegal act on the premises of the child care facility;
  (b) a failure to meet the qualifications for licensure; or
  (c) conduct adverse to the public health, morals, welfare, and safety of children under its care.
(2) The department may also place a department representative as a monitor in a facility, and may assess the cost of that monitoring to the facility, until the licensee has remedied the deficiencies that brought about the department action.
(3) The department may impose civil monetary penalties in accordance with Title 63G, Chapter 4, Administrative Procedures Act, if there has been a failure to comply with the provisions of this chapter, or rules made pursuant to this chapter, as follows:
  (a) if significant problems exist that are likely to lead to the harm of a qualifying child, the department may impose a civil penalty of $50 to $1,000 per day; and
  (b) if significant problems exist that result in actual harm to a qualifying child, the department may impose a civil penalty of $1,050 to $5,000 per day.

Renumbered and Amended by Chapter 111, 2008 General Session
Amended by Chapter 382, 2008 General Session

26-39-602 Offering or providing care in violation of chapter -- Misdemeanor.

Notwithstanding the provisions of Title 26, Chapter 23, Enforcement Provisions and Penalties, a person who provides or offers child care except as provided by this chapter is guilty of a class A misdemeanor.

Renumbered and Amended by Chapter 111, 2008 General Session

Chapter 40
Utah Children's Health Insurance Act

26-40-101 Title.

This chapter is known as the "Utah Children's Health Insurance Act."

Enacted by Chapter 360, 1998 General Session

26-40-102 Definitions.

As used in this chapter:
(1) "Child" means a person who is under 19 years of age.
(2) "Eligible child" means a child who qualifies for enrollment in the program as provided in Section 26-40-105.
(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.

Amended by Chapter 393, 2019 General Session

26-40-103 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;
    (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 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.

Amended by Chapter 393, 2019 General Session

26-40-104 Utah Children's Health Insurance Program Advisory Council.

(1) There is created a Utah Children's Health Insurance Program Advisory Council consisting of at least five and no more than eight members appointed by the executive director of the department. The term of each appointment shall be three years. The appointments shall be staggered at one-year intervals to ensure continuity of the advisory council.
(2) The advisory council shall meet at least quarterly.
(3) The membership of the advisory council shall include at least one representative from each of the following groups:
  (a) child health care providers;
  (b) ethnic populations other than American Indians;
  (c) American Indians;
  (d) health and accident and health insurance providers; and

(e) the general public.
(4) The advisory council shall advise the department on:
(a) benefits design;
(b) eligibility criteria;
(c) outreach;
(d) evaluation; and
(e) special strategies for under-served populations.
(5) 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.

Amended by Chapter 107, 2015 General Session

26-40-105 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.

Amended by Chapter 393, 2019 General Session

26-40-106 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 on 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 on 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 January 31 of each year, the department shall publish the benchmark for dental program benefits established under Subsection (1)(b).
(3) The program benefits for enrollees who are at or below 100% of the federal poverty level are exempt from the benchmark requirements of Subsections (1) and (2).

Amended by Chapter 393, 2019 General Session

26-40-107 Limitation of benefits.

Abortion is not a covered benefit, except as provided in 42 U.S.C. Sec. 1397ee.

Enacted by Chapter 360, 1998 General Session

26-40-108 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.

Amended by Chapter 391, 2010 General Session

26-40-109 Evaluation.

The department shall develop performance measures and annually evaluate the program's performance.

Amended by Chapter 167, 2013 General Session

26-40-110 Managed care -- Contracting for services.

(1) Program benefits provided to a member under the program, as described in Section 26-40-106, 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(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.

(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).

Amended by Chapter 393, 2019 General Session

26-40-115 State contractor -- Employee and dependent health benefit plan coverage.

(1) For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205.5, 63C-9-403, 72-6-107.5, and 79-2-404, "qualified health insurance 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 the benchmark plan determined by the program under Subsection 26-40-106(1)(a), and a contribution level at which the employer pays at least 50% of the premium 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 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.

Amended by Chapter 393, 2019 General Session

26-40-116 Program to encourage appropriate emergency room use -- Application for waivers.

The program is subject to the provisions of Section 26-18-408 and shall apply for waivers in accordance with Subsection 26-18-408(4)(c).

Amended by Chapter 393, 2019 General Session

Chapter 41
Emergency Response for Life-threatening Conditions

Superseded 7/1/2020

26-41-101 Title.

This chapter is known as the "Emergency Injection for Anaphylactic Reaction Act."

Enacted by Chapter 17, 1998 General Session

Effective 7/1/2020

26-41-101 Title.

This chapter is known as "Emergency Response for Life-threatening Conditions."

Amended by Chapter 236, 2019 General Session

Superseded 7/1/2020

26-41-102 Definitions.

As used in this chapter:

(1) "Anaphylaxis" means a potentially life-threatening hypersensitivity to a substance.

(a) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.

(b) Causes of anaphylaxis may include insect sting, food allergy, drug reaction, and exercise.

(2) "Epinephrine auto-injector" means a portable, disposable drug delivery device that contains a measured, single dose of epinephrine that is used to treat a person suffering a potentially fatal anaphylactic reaction.

(3) "Qualified adult" means a person who:

(a) is 18 years of age or older; and
(b) has successfully completed the training program established in Section 26-41-104.
(4) "Qualified entity":
(a) means a facility or organization that employs, contracts with, or has a similar relationship with a qualified adult who is likely to have contact with another person who may experience anaphylaxis; and
(b) includes:
(i) recreation camps;
(ii) an education facility, school, or university;
(iii) a day care facility;
(iv) youth sports leagues;
(v) amusement parks;
(vi) food establishments;
(vii) places of employment; and
(viii) recreation areas.

Amended by Chapter 106, 2017 General Session

Effective 7/1/2020
26-41-102 Definitions.
As used in this chapter:
(1) "Anaphylaxis" means a potentially life-threatening hypersensitivity to a substance.
(a) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.
(b) Causes of anaphylaxis may include insect sting, food allergy, drug reaction, and exercise.
(2) "Asthma action plan" means a written plan:
(a) developed with a school nurse, a student's parent or guardian, and the student's health care provider to help control the student's asthma; and
(b) signed by the student's:
(i) parent or guardian; and
(ii) health care provider.
(3) "Asthma emergency" means an episode of respiratory distress that may include symptoms such as wheezing, shortness of breath, coughing, chest tightness, or breathing difficulty.
(4) "Epinephrine auto-injector" means a portable, disposable drug delivery device that contains a measured, single dose of epinephrine that is used to treat a person suffering a potentially fatal anaphylactic reaction.
(5) "Health care provider" means an individual who is licensed as:
(a) a physician under Title 58, Chapter 67, Utah Medical Practice Act;
(b) a physician under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
(c) an advanced practice registered nurse under Section 58-31b-302; or
(d) a physician assistant under Title 58, Chapter 70a, Utah Physician Assistant Act.
(6) "Qualified adult" means a person who:
(a) is 18 years of age or older; and
(b)
(i) for purposes of administering an epinephrine auto-injector, has successfully completed the training program established in Section 26-41-104; and
(ii) for purposes of administering stock albuterol, has successfully completed the training program established in Section 26-41-104.1.

(7) "Qualified epinephrine auto-injector entity":
(a) means a facility or organization that employs, contracts with, or has a similar relationship with a qualified adult who is likely to have contact with another person who may experience anaphylaxis; and
(b) includes:
(i) recreation camps;
(ii) an education facility, school, or university;
(iii) a day care facility;
(iv) youth sports leagues;
(v) amusement parks;
(vi) food establishments;
(vii) places of employment; and
(viii) recreation areas.
(8) "Qualified stock albuterol entity" means a public or private school that employs, contracts with, or has a similar relationship with a qualified adult who is likely to have contact with another person who may experience an asthma emergency.
(9) "Stock albuterol" means a prescription inhaled medication:
(a) used to treat asthma; and
(b) that may be delivered through a device, including:
(i) an inhaler; or
(ii) a nebulizer with a mouthpiece or mask.

Amended by Chapter 236, 2019 General Session

Superseded 7/1/2020
26-41-103 Voluntary participation.
(1) This chapter does not create a duty or standard of care for:
(a) a person to be trained in the use and storage of epinephrine auto-injectors; or
(b) except as provided in Subsection (5), a qualified entity to store epinephrine auto-injectors on its premises.
(2) Except as provided in Subsections (3) and (5), a decision by a person to successfully complete a training program under Section 26-41-104 and to make emergency epinephrine auto-injectors available under the provisions of this chapter is voluntary.
(3) A school, school board, or school official may not prohibit or dissuade a teacher or other school employee at a primary or secondary school in the state, either public or private, from:
(a) completing a training program under Section 26-41-104;
(b) possessing or storing an epinephrine auto-injector on school property if:
(i) the teacher or school employee is a qualified adult; and
(ii) the possession and storage is in accordance with the training received under Section 26-41-104; or
(c) administering an epinephrine auto-injector to any person, if:
(i) the teacher or school employee is a qualified adult; and
(ii) the administration is in accordance with the training received under Section 26-41-104.
(4) A school, school board, or school official may encourage a teacher or other school employee to volunteer to become a qualified adult.
(5)
(a) Each primary or secondary school in the state, both public and private, shall make an emergency epinephrine auto-injector available to any teacher or other school employee who:

(i) is employed at the school; and
(ii) is a qualified adult.
(b) This section does not require a school described in Subsection (5)(a) to keep more than one emergency epinephrine auto-injector on the school premises, so long as it may be quickly accessed by a teacher or other school employee, who is a qualified adult, in the event of an emergency.
(6) No school, school board, or school official shall retaliate or otherwise take adverse action against a teacher or other school employee for:
(a) volunteering under Subsection (2);
(b) engaging in conduct described in Subsection (3); or
(c) failing or refusing to become a qualified adult.

Amended by Chapter 332, 2015 General Session

Effective 7/1/2020
26-41-103 Voluntary participation.
(1) This chapter does not create a duty or standard of care for:
(a) a person to be trained in the use and storage of epinephrine auto-injectors or stock albuterol; or
(b) except as provided in Subsection (5), a qualified epinephrine auto-injector entity to store epinephrine auto-injectors or a qualified stock albuterol entity to store stock albuterol on its premises.
(2) Except as provided in Subsections (3) and (5), a decision by a person to successfully complete a training program under Section 26-41-104 or 26-41-104.1 and to make emergency epinephrine auto-injectors or stock albuterol available under the provisions of this chapter is voluntary.
(3) A school, school board, or school official may not prohibit or dissuade a teacher or other school employee at a primary or secondary school in the state, either public or private, from:
(a) completing a training program under Section 26-41-104 or 26-41-104.1;
(b) possessing or storing an epinephrine auto-injector or stock albuterol on school property if:
(i) the teacher or school employee is a qualified adult; and
(ii) the possession and storage is in accordance with the training received under Section 26-41-104 or 26-41-104.1; or
(c) administering an epinephrine auto-injector or stock albuterol to any person, if:
(i) the teacher or school employee is a qualified adult; and
(ii) the administration is in accordance with the training received under Section 26-41-104 or 26-41-104.1.
(4) A school, school board, or school official may encourage a teacher or other school employee to volunteer to become a qualified adult.
(5)
(a) Each primary or secondary school in the state, both public and private, shall make an emergency epinephrine auto-injector available to any teacher or other school employee who:
(i) is employed at the school; and
(ii) is a qualified adult.
(b) This section does not require a school described in Subsection (5)(a) to keep more than one emergency epinephrine auto-injector on the school premises, so long as it may be quickly accessed by a teacher or other school employee, who is a qualified adult, in the event of an emergency.

(6)
(a) Each primary or secondary school in the state, both public and private, may make stock albuterol available to any school employee who:
(i) is employed at the school; and
(ii) is a qualified adult.
(b) A qualified adult may administer stock albuterol to a student who:
(i) has a diagnosis of asthma by a health care provider;
(ii) has a current asthma action plan on file with the school; and
(iii) is showing symptoms of an asthma emergency as described in the student's asthma action plan.
(c) This Subsection (6) may not be interpreted to relieve a student's parent or guardian of providing a student's medication or create an expectation that a school will have stock albuterol available.
(7) No school, school board, or school official shall retaliate or otherwise take adverse action against a teacher or other school employee for:
(a) volunteering under Subsection (2);
(b) engaging in conduct described in Subsection (3); or
(c) failing or refusing to become a qualified adult.

Amended by Chapter 236, 2019 General Session

Superseded 7/1/2020
26-41-104 Training in use and storage of epinephrine auto-injector.
(1)
(a) Each primary and secondary school in the state, both public and private, shall make initial and annual refresher training, regarding the storage and emergency use of an epinephrine auto-injector, available to any teacher or other school employee who volunteers to become a qualified adult.
(b) The training described in Subsection (1)(a) may be provided by the school nurse, or other person qualified to provide such training, designated by the school district physician, the medical director of the local health department, or the local emergency medical services director.
(2) A person who provides training under Subsection (1) or (6) shall include in the training:
(a) techniques for recognizing symptoms of anaphylaxis;
(b) standards and procedures for the storage and emergency use of epinephrine auto-injectors;
(c) emergency follow-up procedures, including calling the emergency 911 number and contacting, if possible, the student's parent and physician; and
(d) written materials covering the information required under this Subsection (2).
(3) A qualified adult shall retain for reference the written materials prepared in accordance with Subsection (2)(d).
(4) A public school shall permit a student to possess an epinephrine auto-injector or possess and self-administer an epinephrine auto-injector if:
(a) the student's parent or guardian signs a statement:
(i) authorizing the student to possess or possess and self-administer an epinephrine auto-injector; and
(ii) acknowledging that the student is responsible for, and capable of, possessing or possessing and self-administering an epinephrine auto-injector; and
(b) the student's health care provider provides a written statement that states that:

(i) it is medically appropriate for the student to possess or possess and self-administer an epinephrine auto-injector; and
(ii) the student should be in possession of the epinephrine auto-injector at all times.
(5) The Utah Department of Health, in cooperation with the state superintendent of public instruction, shall design forms to be used by public schools for the parental and health care providers statements described in Subsection (4).
(6)
(a) The department:
(i) shall approve educational programs conducted by other persons, to train:
(A) people under Subsection (6)(b) of this section, regarding the proper use and storage of emergency epinephrine auto-injectors; and
(B) a qualified entity regarding the proper storage and emergency use of epinephrine auto-injectors; and
(ii) may, as funding is available, conduct educational programs to train people regarding the use of and storage of emergency epinephrine auto-injectors.
(b) A person who volunteers to receive training as a qualified adult to administer an epinephrine auto-injector under the provisions of this Subsection (6) shall demonstrate a need for the training to the department, which may be based upon occupational, volunteer, or family circumstances, and shall include:
(i) camp counselors;
(ii) scout leaders;
(iii) forest rangers;
(iv) tour guides; and
(v) other persons who have or reasonably expect to have contact with at least one other person as a result of the person's occupational or volunteer status.

Amended by Chapter 332, 2015 General Session

Effective 7/1/2020
26-41-104 Training in use and storage of epinephrine auto-injector.
(1)
(a) Each primary and secondary school in the state, both public and private, shall make initial and annual refresher training, regarding the storage and emergency use of an epinephrine auto-injector, available to any teacher or other school employee who volunteers to become a qualified adult.
(b) The training described in Subsection (1)(a) may be provided by the school nurse, or other person qualified to provide such training, designated by the school district physician, the medical director of the local health department, or the local emergency medical services director.
(2) A person who provides training under Subsection (1) or (6) shall include in the training:
(a) techniques for recognizing symptoms of anaphylaxis;
(b) standards and procedures for the storage and emergency use of epinephrine auto-injectors;
(c) emergency follow-up procedures, including calling the emergency 911 number and contacting, if possible, the student's parent and physician; and
(d) written materials covering the information required under this Subsection (2).
(3) A qualified adult shall retain for reference the written materials prepared in accordance with Subsection (2)(d).

(4) A public school shall permit a student to possess an epinephrine auto-injector or possess and self-administer an epinephrine auto-injector if:
(a) the student's parent or guardian signs a statement:
(i) authorizing the student to possess or possess and self-administer an epinephrine auto-injector; and
(ii) acknowledging that the student is responsible for, and capable of, possessing or possessing and self-administering an epinephrine auto-injector; and
(b) the student's health care provider provides a written statement that states that:
(i) it is medically appropriate for the student to possess or possess and self-administer an epinephrine auto-injector; and
(ii) the student should be in possession of the epinephrine auto-injector at all times.
(5) The department, in cooperation with the state superintendent of public instruction, shall design forms to be used by public and private schools for the parental and health care providers statements described in Subsection (4).
(6)
(a) The department:
(i) shall approve educational programs conducted by other persons, to train:
(A) people under Subsection (6)(b) of this section, regarding the proper use and storage of emergency epinephrine auto-injectors; and
(B) a qualified epinephrine auto-injector entity regarding the proper storage and emergency use of epinephrine auto-injectors; and
(ii) may, as funding is available, conduct educational programs to train people regarding the use of and storage of emergency epinephrine auto-injectors.
(b) A person who volunteers to receive training as a qualified adult to administer an epinephrine auto-injector under the provisions of this Subsection (6) shall demonstrate a need for the training to the department, which may be based upon occupational, volunteer, or family circumstances, and shall include:
(i) camp counselors;
(ii) scout leaders;
(iii) forest rangers;
(iv) tour guides; and
(v) other persons who have or reasonably expect to have contact with at least one other person as a result of the person's occupational or volunteer status.

Amended by Chapter 236, 2019 General Session

Effective 7/1/2020
26-41-104.1 Training in use and storage of stock albuterol.
(1)
(a) Each primary and secondary school in the state, both public and private, shall make initial and annual refresher training regarding the storage and emergency use of stock albuterol available to a teacher or school employee who volunteers to become a qualified adult.
(b) The training described in Subsection (1)(a) shall be provided by the department.
(2) A person who provides training under Subsection (1) or (6) shall include in the training:
(a) techniques for recognizing symptoms of an asthma emergency;
(b) standards and procedures for the storage and emergency use of stock albuterol;
(c) emergency follow-up procedures, and contacting, if possible, the student's parent; and
(d) written materials covering the information required under this Subsection (2).

(3) A qualified adult shall retain for reference the written materials prepared in accordance with Subsection (2)(d).
(4)
(a) A public or private school shall permit a student to possess and self-administer asthma medication if:
(i) the student's parent or guardian signs a statement:
(A) authorizing the student to self-administer asthma medication; and
(B) acknowledging that the student is responsible for, and capable of, self-administering the asthma medication; and
(ii) the student's health care provider provides a written statement that states:
(A) it is medically appropriate for the student to self-administer asthma medication and be in possession of asthma medication at all times; and
(B) the name of the asthma medication prescribed or authorized for the student's use.
(b) Section 53G-8-205 does not apply to the possession and self-administration of asthma medication in accordance with this section.
(5) The department, in cooperation with the state superintendent of public instruction, shall design forms to be used by public and private schools for the parental and health care provider statements described in Subsection (4).
(6) The department:
(a) shall approve educational programs conducted by other persons to train:
(i) people under Subsection (6)(b), regarding the proper use and storage of stock albuterol; and
(ii) a qualified stock albuterol entity regarding the proper storage and emergency use of stock albuterol; and
(b) may conduct educational programs to train people regarding the use of and storage of stock albuterol.

Enacted by Chapter 236, 2019 General Session

Superseded 7/1/2020

26-41-105 Authority to obtain and use an epinephrine auto-injector.

(1) A qualified adult who is a teacher or other school employee at a public or private primary or secondary school in the state, or a school nurse, may obtain from the school district physician, the medical director of the local health department, or the local emergency medical services director a prescription for epinephrine auto-injectors.
(2) A qualified adult may obtain from a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs, a prescription for an epinephrine auto-injector.
(3) A qualified adult:
(a) may immediately administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis when a physician is not immediately available; and
(b) shall initiate emergency medical services or other appropriate medical follow-up in accordance with the training materials retained under Section 26-41-104 after administering an epinephrine auto-injector.
(4)
(a) A qualified entity that complies with Subsection (4)(b), may obtain from a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs, a prescription for a supply of epinephrine auto-injectors, for:
(i) storing the epinephrine auto-injectors on the qualified entity's premises; and

(ii) use by a qualified adult in accordance with Subsection (3).
(b) A qualified entity shall:
(i) designate an individual to complete an initial and annual refresher training program regarding the proper storage and emergency use of an epinephrine auto-injector available to a qualified adult; and
(ii) store epinephrine auto-injectors in accordance with the standards established by the department in Section 26-41-107.

Amended by Chapter 332, 2015 General Session

Effective 7/1/2020

26-41-105 Authority to obtain and use an epinephrine auto-injector or stock albuterol.

(1) A qualified adult who is a teacher or other school employee at a public or private primary or secondary school in the state, or a school nurse, may obtain from the school district physician, the medical director of the local health department, or the local emergency medical services director a prescription for epinephrine auto-injectors or stock albuterol.
(2) A qualified adult may obtain from a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs, a prescription for an epinephrine auto-injector or stock albuterol.
(3) A qualified adult:
(a) may immediately administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis when a physician is not immediately available; and
(b) shall initiate emergency medical services or other appropriate medical follow-up in accordance with the training materials retained under Section 26-41-104 after administering an epinephrine auto-injector.
(4) If a school nurse is not immediately available, a qualified adult:
(a) may immediately administer stock albuterol to an individual who:
(i) has a diagnosis of asthma by a health care provider;
(ii) has a current asthma action plan on file with the school; and
(iii) is showing symptoms of an asthma emergency as described in the student's asthma action plan; and
(b) shall initiate appropriate medical follow-up in accordance with the training materials retained under Section 26-41-104.1 after administering stock albuterol.
(5)
(a) A qualified entity that complies with Subsection (5)(b) or (c), may obtain from a physician, pharmacist, or any other person authorized to prescribe or dispense prescription drugs, a prescription for a supply of epinephrine auto-injectors or stock albuterol, respectively, for:
(i) storing:
(A) the epinephrine auto-injectors on the qualified epinephrine auto-injector entity's premises; and
(B) stock albuterol on the qualified stock albuterol entity's premises; and
(ii) use by a qualified adult in accordance with Subsection (3) or (4).
(b) A qualified epinephrine auto-injector entity shall:
(i) designate an individual to complete an initial and annual refresher training program regarding the proper storage and emergency use of an epinephrine auto-injector available to a qualified adult; and
(ii) store epinephrine auto-injectors in accordance with the standards established by the department in Section 26-41-107.

(c) A qualified stock albuterol entity shall:
(i) designate an individual to complete an initial and annual refresher training program regarding the proper storage and emergency use of stock albuterol available to a qualified adult; and
(ii) store stock albuterol in accordance with the standards established by the department in Section 26-41-107.

Amended by Chapter 236, 2019 General Session

Superseded 7/1/2020

26-41-106 Immunity from liability.

(1) The following, if acting in good faith, are not liable in any civil or criminal action for any act taken or not taken under the authority of this chapter with respect to an anaphylactic reaction:
(a) a qualified adult;
(b) a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs;
(c) a person who conducts training described in Section 26-41-104; and
(d) a qualified entity.
(2) Section 53G-9-502 does not apply to the administration of an epinephrine auto-injector in accordance with this chapter.
(3) This section does not eliminate, limit, or reduce any other immunity from liability or defense against liability that may be available under state law.

Amended by Chapter 415, 2018 General Session

Effective 7/1/2020

26-41-106 Immunity from liability.

(1) The following, if acting in good faith, are not liable in any civil or criminal action for any act taken or not taken under the authority of this chapter with respect to an anaphylactic reaction or asthma emergency:
(a) a qualified adult;
(b) a physician, pharmacist, or any other person or entity authorized to prescribe or dispense prescription drugs;
(c) a person who conducts training described in Section 26-41-104 or 26-41-104.1;
(d) a qualified epinephrine auto-injector entity; and
(e) a qualified stock albuterol entity.
(2) Section 53G-9-502 does not apply to the administration of an epinephrine auto-injector or stock albuterol in accordance with this chapter.
(3) This section does not eliminate, limit, or reduce any other immunity from liability or defense against liability that may be available under state law.

Amended by Chapter 236, 2019 General Session

Superseded 7/1/2020

26-41-107 Administrative rulemaking authority.

The department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:
(1) establish and approve training programs in accordance with Section 26-41-104;

(2) establish a procedure for determining who is eligible for training as a qualified adult under Subsection 26-41-104(6)(b)(v); and
(3) establish standards for storage of emergency auto-injectors by a qualified entity under Section 26-41-104.

Enacted by Chapter 332, 2015 General Session

Effective 7/1/2020
26-41-107 Administrative rulemaking authority.
The department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:
(1) establish and approve training programs in accordance with Sections 26-41-104 and 26-41-104.1;
(2) establish a procedure for determining who is eligible for training as a qualified adult under Subsection 26-41-104(6)(b)(v); and
(3) establish standards for storage of:
(a) emergency auto-injectors by a qualified epinephrine auto-injector entity under Section 26-41-104; and
(b) stock albuterol by a qualified stock albuterol entity under Section 26-41-104.1.

Amended by Chapter 236, 2019 General Session

Chapter 43
Disclosure of Ingredients in Cigarette and Tobacco Products Act

26-43-101 Title.
This chapter shall be known as the "Disclosure of Ingredients in Cigarette and Tobacco Products Act."

Enacted by Chapter 73, 1998 General Session

26-43-102 Gathering of information.
The department shall obtain annually publicly available information regarding cigarettes and tobacco products from other states and sources concerning:
(1) the presence of the following substances in detectable levels in a burned state and, if the cigarette or tobacco product is typically burned when consumed, in a burned state:
(a) ammonia or ammonia compounds;
(b) arsenic;
(c) cadmium;
(d) formaldehyde; and
(e) lead; and
(2) a nicotine yield rating for the cigarette or tobacco product for which a rating has been developed.

Enacted by Chapter 73, 1998 General Session

26-43-103 Disclosure of information.

Information obtained by the department under this chapter is a public record and may be disclosed in accordance with Section 63G-2-201 and disseminated generally by the department.

Amended by Chapter 382, 2008 General Session

Chapter 45
Genetic Testing Privacy Act

26-45-101 Title.

This chapter is known as the "Genetic Testing Privacy Act."

Enacted by Chapter 120, 2002 General Session

26-45-102 Definitions.

As used in this chapter:

(1) "Blood relative" means a person's biologically related:
- (a) parent;
- (b) grandparent;
- (c) child;
- (d) grandchild;
- (e) sibling;
- (f) uncle;
- (g) aunt;
- (h) nephew;
- (i) niece; or
- (j) first cousin.

(2) "DNA" means deoxyribonucleic acid, ribonucleic acid, and chromosomes, which may be analyzed to detect heritable diseases or conditions, including the identification of carriers, predicting risk of disease, or establishing a clinical diagnosis.

(3) "DNA sample" means any human biological specimen from which DNA can be extracted, or DNA extracted from such specimen.

(4)
- (a) "Genetic analysis" or "genetic test" means the testing or analysis of an identifiable individual's DNA that results in information that is derived from the presence, absence, alteration, or mutation of an inherited gene or genes, or the presence or absence of a specific DNA marker or markers.
- (b) "Genetic analysis" or "genetic test" does not mean:
  - (i) a routine physical examination;
  - (ii) a routine chemical, blood, or urine analysis;
  - (iii) a test to identify the presence of drugs or HIV infection; or
  - (iv) a test performed due to the presence of signs, symptoms, or other manifestations of a disease, illness, impairment, or other disorder.

(5) "Individual" means the person from whose body the DNA sample originated.

(6) "Person" means any person, organization, or entity other than the individual.

(7)

(a) "Private genetic information" means any information about an identifiable individual that is derived from the presence, absence, alteration, or mutation of an inherited gene or genes, or the presence or absence of a specific DNA marker or markers, and which has been obtained:
(i) from a genetic test or analysis of the individual's DNA; or
(ii) from a genetic test or analysis of a person's DNA to whom the individual is a blood relative.
(b) "Private genetic information" does not include information that is derived from:
(i) a routine physical examination;
(ii) a routine chemical, blood, or urine analysis;
(iii) a test to identify the presence of drugs or HIV infection; or
(iv) a test performed due to the presence of signs, symptoms, or other manifestations of a disease, illness, impairment, or other disorder.

Enacted by Chapter 120, 2002 General Session

26-45-103 Restrictions on employers.

(1) Except as provided in Subsection (2), an employer, as defined in Section 34A-2-103, may not in connection with a hiring, promotion, retention, or other related decision:
(a) access or otherwise take into consideration private genetic information about an individual;
(b) request or require an individual to consent to a release for the purpose of accessing private genetic information about the individual;
(c) request or require an individual or his blood relative to submit to a genetic test; and
(d) inquire into or otherwise take into consideration the fact that an individual or his blood relative has taken or refused to take a genetic test.
(2)
(a) Notwithstanding Subsection (1), an employer may seek an order compelling the disclosure of private genetic information held by an individual or third party pursuant to Subsection (2)(b) in connection with:
(i) an employment-related judicial or administrative proceeding in which the individual has placed his health at issue; or
(ii) an employment-related decision in which the employer has a reasonable basis to believe that the individual's health condition poses a real and unjustifiable safety risk requiring the change or denial of an assignment.
(b)
(i) An order compelling the disclosure of private genetic information pursuant to this Subsection (2) may only be entered upon a finding that:
(A) other ways of obtaining the private information are not available or would not be effective; and
(B) there is a compelling need for the private genetic information which substantially outweighs the potential harm to the privacy interests of the individual.
(ii) An order compelling the disclosure of private genetic information pursuant to this Subsection (2) shall:
(A) limit disclosure to those parts of the record containing information essential to fulfill the objective of the order;
(B) limit disclosure to those persons whose need for the information is the basis of the order; and
(C) include such other measures as may be necessary to limit disclosure for the protection of the individual.

Enacted by Chapter 120, 2002 General Session

26-45-104 Restrictions on health insurers.

(1) Except as provided in Subsection (2), an insurer offering health care insurance as defined in Section 31A-1-301 may not in connection with the offer or renewal of an insurance product or in the determination of premiums, coverage, renewal, cancellation, or any other underwriting decision that pertains directly to the individual or any group of which the individual is a member that purchases insurance jointly:

(a) access or otherwise take into consideration private genetic information about an asymptomatic individual;

(b) request or require an asymptomatic individual to consent to a release for the purpose of accessing private genetic information about the individual;

(c) request or require an asymptomatic individual or his blood relative to submit to a genetic test; and

(d) inquire into or otherwise take into consideration the fact that an asymptomatic individual or his blood relative has taken or refused to take a genetic test.

(2) An insurer offering health care insurance:

(a) may request information regarding the necessity of a genetic test, but not the results of the test, if a claim for payment for the test has been made against an individual's health insurance policy;

(b) may request that portion of private genetic information that is necessary to determine the insurer's obligation to pay for health care services where:

(i) the primary basis for rendering such services to an individual is the result of a genetic test; and

(ii) a claim for payment for such services has been made against the individual's health insurance policy;

(c) may only store information obtained under this Subsection (2) in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996; and

(d) may only use or otherwise disclose the information obtained under this Subsection (2) in connection with a proceeding to determine the obligation of an insurer to pay for a genetic test or health care services, provided that, in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996, the insurer makes a reasonable effort to limit disclosure to the minimum necessary to carry out the purposes of the disclosure.

(3)

(a) An insurer may, to the extent permitted by Subsection (2), seek an order compelling the disclosure of private genetic information held by an individual or third party.

(b) An order authorizing the disclosure of private genetic information pursuant to this Subsection (2) shall:

(i) limit disclosure to those parts of the record containing information essential to fulfill the objectives of the order;

(ii) limit disclosure to those persons whose need for the information is the basis for the order; and

(iii) include such other measures as may be necessary to limit disclosure for the protection of the individual.

(4) Nothing in this section may be construed as restricting the ability of an insurer to use information other than private genetic information to take into account the health status of an individual, group, or population in determining premiums or making other underwriting decisions.

(5) Nothing in this section may be construed as requiring an insurer to pay for genetic testing.
(6) Information maintained by an insurer about an individual under this section may be redisclosed:
(a) to protect the interests of the insurer in detecting, prosecuting, or taking legal action against criminal activity, fraud, material misrepresentations, and material omissions;
(b) to enable business decisions to be made about the purchase, transfer, merger, reinsurance, or sale of all or part of the insurer's business; and
(c) to the commissioner of insurance upon formal request.

Enacted by Chapter 120, 2002 General Session

26-45-105 Private right of action.
(1) An individual whose legal rights arising under this chapter have been violated after June 30, 2003, may recover damages and be granted equitable relief in a civil action.
(2) Any insurance company or employer who violates the legal rights of an individual arising from this chapter shall be liable to the individual for each separate violation in an amount equal to:
(a) actual damages sustained as a result of the violation;
(b)
(i) $100,000 if the violation is the result of an intentional and wilful act; or
(ii) punitive damages if the violation is the result of a malicious act; and
(c) reasonable attorneys' fees.

Enacted by Chapter 120, 2002 General Session

26-45-106 Enforcement.
(1) Whenever the attorney general has reason to believe that any person is using or is about to use any method, act, or practice in violation of the provisions of this chapter, and that proceedings would be in the public interest, the attorney general may bring an action against the person to restrain or enjoin the use of such method, act, or practice.
(2) In addition to restraining or enjoining the use of a method, act, or practice, the court may, after June 30, 2003, require the payment of:
(a) a civil fine of not more than $25,000 for each separate intentional violation; and
(b) reasonable costs of investigation and litigation, including reasonable attorneys' fees.

Enacted by Chapter 120, 2002 General Session

Chapter 46
Utah Health Care Workforce Financial Assistance Program

26-46-101 Definitions.
(1) "Geriatric professional" means a person who:
(a) is a licensed:
(i) health care professional;
(ii) social worker;
(iii) occupational therapist;
(iv) pharmacist;
(v) physical therapist; or

(vi) psychologist; and
(b) is determined by the department to have adequate advanced training in geriatrics to prepare the person to provide specialized geriatric care within the scope of the person's profession.
(2) "Health care professional" means:
(a) a licensed:
(i) physician;
(ii) physician assistant;
(iii) nurse;
(iv) dentist; or
(v) mental health therapist; or
(b) another licensed health care professional designated by the department by rule.
(3) "Underserved area" means an area designated by the department as underserved by health care professionals, based upon the results of a needs assessment developed by the department in consultation with the Utah Health Care Workforce Financial Assistance Program Advisory Committee created under Section 26-46-103.

Amended by Chapter 97, 2009 General Session

26-46-102 Creation of program -- Duties of department.
(1) There is created within the department the Utah Health Care Workforce Financial Assistance Program to provide, within funding appropriated by the Legislature for this purpose:
(a) professional education scholarships and loan repayment assistance to health care professionals who locate or continue to practice in underserved areas; and
(b) loan repayment assistance to geriatric professionals who locate or continue to practice in underserved areas.
(2) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules governing the administration of the program, including rules that address:
(a) application procedures;
(b) eligibility criteria;
(c) selection criteria;
(d) service conditions, which at a minimum shall include professional service in an underserved area for a minimum period of time by any person receiving a scholarship or loan repayment assistance;
(e) penalties for failure to comply with service conditions or other terms of a scholarship or loan repayment contract;
(f) criteria for modifying or waiving service conditions or penalties in case of extreme hardship or other good cause; and
(g) administration of contracts entered into before the effective date of this act, between the department and scholarship or loan repayment recipients, as authorized by law.
(3) The department shall seek and consider the recommendations of the Utah Health Care Workforce Financial Assistance Program Advisory Committee created under Section 26-46-103 as it develops and modifies rules to administer the program.
(4) Funding for the program:
(a) shall be a line item within the appropriations act;
(b) shall be nonlapsing unless designated otherwise by the Legislature; and
(c) may be used to cover administrative costs of the program, including reimbursement expenses of the Utah Health Care Workforce Financial Assistance Program Advisory Committee created under Section 26-46-103.

(5) Loan repayments and payments resulting from breach of contract are dedicated credits to the program.
(6) The department shall prepare an annual report on the revenues, expenditures, and outcomes of the program.

Amended by Chapter 97, 2009 General Session

26-46-103 Advisory committee -- Membership -- Compensation -- Duties.
(1) There is created the Utah Health Care Workforce Financial Assistance Program Advisory Committee consisting of the following 13 members appointed by the executive director, eight of whom shall be residents of rural communities:
(a) one rural representative of Utah Hospitals and Health Systems, nominated by the association;
(b) two rural representatives of the Utah Medical Association, nominated by the association;
(c) one representative of the Utah Academy of Physician Assistants, nominated by the association;
(d) one representative of the Association for Utah Community Health, nominated by the association;
(e) one representative of the Utah Dental Association, nominated by the association;
(f) one representative of mental health therapists, selected from nominees submitted by mental health therapist professional associations;
(g) one representative of the Association of Local Health Officers, nominated by the association;
(h) one representative of a low-income advocacy group, nominated by a Utah health and human services coalition that represents underserved populations;
(i) one nursing program faculty member, nominated by the Statewide Deans and Directors Committee;
(j) one administrator of a long-term care facility, nominated by the Utah Health Care Association;
(k) one nursing administrator, nominated by the Utah Nurses Association; and
(l) one geriatric professional who is:
(i) determined by the department to have adequate advanced training in geriatrics to prepare the person to provide specialized geriatric care within the scope of the person's profession; and
(ii) nominated by a professional association for the profession of which the person is a member.
(2) An appointment to the committee shall be for a four-year term unless the member is appointed to complete an unexpired term. The executive director may also adjust the length of term at the time of appointment or reappointment so that approximately 1/2 the committee is appointed every two years. The executive director shall annually appoint a committee chair from among the members of the committee.
(3) The committee shall meet at the call of the chair, at least three members of the committee, or the executive director, but no less frequently than once each calendar year.
(4) A majority of the members of the committee constitutes a quorum. The action of a majority of a quorum constitutes the action of the committee.
(5) 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.
(6) The committee shall:

(a) make recommendations to the department for the development and modification of rules to administer the Utah Health Care Workforce Financial Assistance Program; and
(b) advise the department on the development of a needs assessment tool for identifying underserved areas.
(7) As funding permits, the department shall provide staff and other administrative support to the committee.

Amended by Chapter 126, 2017 General Session

Chapter 46a
Rural Physician Loan Repayment Program

26-46a-101 Title.
This chapter is known as "Rural Physician Loan Repayment Program."

Enacted by Chapter 136, 2015 General Session

26-46a-102 Definitions.
As used in this chapter:
(1) "Hospital" means a general acute hospital, as defined in Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.
(2) "Physician" means a person:
(a) licensed as a physician under Title 58, Chapter 67, Utah Medical Practice Act; or
(b) licensed as a physician under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(3) "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 (3)(a).
(4) "Rural hospital" means a hospital located within a rural county.

Amended by Chapter 330, 2018 General Session

26-46a-103 Rural Physician Loan Repayment Program -- Purpose -- Repayment limit -- Funding -- Reporting -- Rulemaking -- Advisory committee.
(1) There is created within the department the Rural Physician Loan Repayment Program to provide, within funding appropriated by the Legislature for this purpose, education loan repayment assistance to physicians in accordance with Subsection (2).
(2) The department may enter into an education loan repayment assistance contract with a physician if:
(a) the physician:
(i) locates or continues to practice in a rural county; and
(ii) has a written commitment from a rural hospital that the hospital will provide education loan repayment assistance to the physician;
(b) the assistance provided by the program does not exceed the assistance provided by the rural hospital; and

(c) the physician is otherwise eligible for assistance under administrative rules adopted under Subsection (6).

(3) Funding for the program:

(a) shall be a line item within an appropriations act;

(b) may be used to pay for the per diem and travel expenses of the Rural Physician Loan Repayment Program Advisory Committee under Subsection 26-46a-104(5); and

(c) may be used to pay for department expenses incurred in the administration of the program:

(i) including administrative support provided to the Rural Physician Loan Repayment Program Advisory Committee created under Subsection 26-46a-104(7); and

(ii) in an amount not exceeding 10% of funding for the program.

(4) Refunds of loan repayment assistance, penalties for breach of contract, and other payments to the program are dedicated credits to the program.

(5) The department shall prepare an annual report of the program's revenues, expenditures, and outcomes.

(6)

(a) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules governing the administration of the program, including rules that address:

(i) application procedures;

(ii) eligibility criteria;

(iii) verification of the amount provided by a rural hospital to a physician for repayment of the physician's education loans;

(iv) service conditions, which at a minimum shall include professional service by the physician in the rural hospital providing loan repayment assistance to the physician;

(v) selection criteria and assistance amounts;

(vi) penalties for failure to comply with service conditions or other terms of a loan repayment assistance contract; and

(vii) criteria for modifying or waiving service conditions or penalties in the case of extreme hardship or for other good cause.

(b) The department shall seek and consider the recommendations of the Rural Physician Loan Repayment Program Advisory Committee created under Section 26-46a-104 as it develops and modifies rules to administer the program.

Enacted by Chapter 136, 2015 General Session

26-46a-104 Rural Physician Loan Repayment Program Advisory Committee -- Membership -- Compensation -- Duties.

(1) There is created the Rural Physician Loan Repayment Program Advisory Committee consisting of the following eight members appointed by the executive director:

(a) two legislators whose districts include rural counties;

(b) five administrators of rural hospitals nominated by an association representing Utah hospitals, no more than two of whom are employed by hospitals affiliated by ownership; and

(c) a physician currently practicing in a rural county.

(2) An appointment to the committee shall be for a four-year term unless the member is appointed to complete an unexpired term. The executive director shall adjust the length of term at the time of appointment or reappointment so that approximately one-half of the committee is appointed every two years. The executive director shall annually appoint a committee chair from among the members of the committee.

(3)

(a) The committee shall meet at the call of:
(i) the chair;
(ii) at least three members of the committee; or
(iii) the executive director.
(b) The committee shall meet at least once each calendar year.
(4) A majority of the members of the committee constitutes a quorum. The action of a majority of a quorum constitutes the action of the committee.
(5) 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.
(6) The committee shall make recommendations to the department for the development and modification of rules to administer the Rural Physician Loan Repayment Program.
(7) As funding permits, the department shall provide staff and other administrative support to the committee.

Enacted by Chapter 136, 2015 General Session

Chapter 47
Health Care Assistance Act

26-47-101 Title.

This chapter is known as the "Health Care Assistance Act."

Enacted by Chapter 273, 2005 General Session

26-47-102 Prescription Drug Assistance Program.

(1) No later than October 1, 2003, the department shall implement a Prescription Drug Assistance Program. The program shall assist persons seeking information about how to obtain prescription drugs at a reduced price or no cost. The program shall:
(a) collect eligibility and enrollment information about programs that make prescription drugs available to consumers at a reduced price or no cost;
(b) provide information collected under Subsection (1)(a) to consumers upon request via a toll-free phone line, the Internet, and mail;
(c) inform pharmacists and other health care providers of the Prescription Drug Assistance Program; and
(d) assist consumers in completing applications to participate in programs identified under Subsection (1)(a).
(2) Any pharmaceutical manufacturer, distributor, or wholesaler operating in the state shall:
(a) notify the department of any program operated by it to provide prescription drugs to consumers at a reduced price or no cost; and
(b) provide the department with information about eligibility, enrollment, and benefits.
(3) Pharmacies, as defined in Title 58, Chapter 17b, Pharmacy Practice Act, shall notify their patients of the Prescription Drug Assistance Program. This notification shall include displaying the program's toll-free number, and may include distributing a brochure or oral communication.

(4) The department may accept grants, gifts, and donations of money or property for use by the Prescription Drug Assistance Program.

Amended by Chapter 167, 2013 General Session

26-47-103 Department to award grants for assistance to persons with bleeding disorders.

(1) For purposes of this section:
  (a) "Hemophilia services" means a program for medical care, including the costs of blood transfusions, and the use of blood derivatives and blood clotting factors.
  (b) "Person with a bleeding disorder" means a person:
    (i) who is medically diagnosed with hemophilia or a bleeding disorder;
    (ii) who is not eligible for Medicaid or the Children's Health Insurance Program; and
    (iii) who meets one or more of the following:
      (A) the person's insurance coverage excludes coverage for hemophilia services;
      (B) the person has exceeded the person's insurance plan's annual maximum benefits;
      (C) the person has exceeded the person's annual or lifetime maximum benefits payable under private health insurance; or
      (D) the premiums for the person's private insurance coverage, or cost sharing under private coverage, are greater than a percentage of the person's annual adjusted gross income as established by the department by administrative rule.
(2)
  (a) Within appropriations specified by the Legislature for this purpose, the department shall make grants to public and nonprofit entities who assist persons with bleeding disorders with the cost of obtaining hemophilia services or the cost of insurance premiums for coverage of hemophilia services.
  (b) Applicants for grants under this section:
    (i) shall be submitted to the department in writing; and
    (ii) shall comply with Subsection (3).
(3) Applications for grants under this section shall include:
  (a) a statement of specific, measurable objectives, and the methods to be used to assess the achievement of those objectives;
  (b) a description of the personnel responsible for carrying out the activities of the grant along with a statement justifying the use of any grant funds for the personnel;
  (c) letters and other forms of evidence showing that efforts have been made to secure financial and professional assistance and support for the services to be provided under the grant;
  (d) a list of services to be provided by the applicant;
  (e) the schedule of fees to be charged by the applicant; and
  (f) other provisions as determined by the department.
(4) The department may accept grants, gifts, and donations of money or property for use by the grant program.
(5) The department shall establish rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, governing the application form, process, and criteria it will use in awarding grants under this section.

Amended by Chapter 181, 2017 General Session

Chapter 49
Uniform Emergency Volunteer Health Practitioners Act

Part 1
General Provisions

26-49-101 Title.

This chapter is known as the "Uniform Emergency Volunteer Health Practitioners Act."

Enacted by Chapter 242, 2008 General Session

26-49-102 Definitions.

As used in this chapter:

(1) "Department of Health" shall have the meaning provided for in Section 26-1-4.

(2) "Disaster relief organization" means an entity that:

(a) provides emergency or disaster relief services that include health or veterinary services provided by volunteer health practitioners;

(b) is designated or recognized as a provider of the services described in Subsection (2)(a) under a disaster response and recovery plan adopted by:

(i) an agency of the federal government;

(ii) the state Department of Health; or

(iii) a local health department; and

(c) regularly plans and conducts its activities in coordination with:

(i) an agency of the federal government;

(ii) the Department of Health; or

(iii) a local health department.

(3) "Emergency" means a "state of emergency" as defined in Section 53-2a-203.

(4) "Emergency declaration" means a declaration made in accordance with Section 53-2a-206 or 53-2a-208.

(5) "Emergency Management Assistance Compact" means the interstate compact approved by Congress by Public Law No. 104-321, 110 Stat. 3877 and adopted by Utah in Title 53, Chapter 2a, Part 4, Emergency Management Assistance Compact.

(6) "Entity" means a person other than an individual.

(7) "Health facility" means an entity licensed under the laws of this or another state to provide health or veterinary services.

(8) "Health practitioner" means an individual licensed under Utah law or another state to provide health or veterinary services.

(9) "Health services" means the provision of treatment, care, advice, guidance, other services, or supplies related to the health or death of individuals or human populations, to the extent necessary to respond to an emergency, including:

(a) the following, concerning the physical or mental condition or functional status of an individual or affecting the structure or function of the body:

(i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; or

(ii) counseling, assessment, procedures, or other services;

(b) selling or dispensing a drug, a device, equipment, or another item to an individual in accordance with a prescription; and

(c) funeral, cremation, cemetery, or other mortuary services.

(10) "Host entity":
(a) means an entity operating in Utah that:
(i) uses volunteer health practitioners to respond to an emergency; and
(ii) is responsible during an emergency, for actually delivering health services to individuals or human populations, or veterinary services to animals or animal populations; and
(b) may include disaster relief organizations, hospitals, clinics, emergency shelters, health care provider offices, or any other place where volunteer health practitioners may provide health or veterinary services.
(11)
(a) "License" means authorization by a state to engage in health or veterinary services that are unlawful without authorization.
(b) "License" includes authorization under this title to an individual to provide health or veterinary services based upon a national or state certification issued by a public or private entity.
(12) "Local health department" shall have the meaning provided for in Subsection 26A-1-102(5).
(13) "Person" means an individual, corporation, business trust, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
(14) "Scope of practice" means the extent of the authorization to provide health or veterinary services granted to a health practitioner by a license issued to the practitioner in the state in which the principal part of the practitioner's services are rendered, including any conditions imposed by the licensing authority.
(15) "State" means:
(a) a state of the United States;
(b) the District of Columbia;
(c) Puerto Rico;
(d) the United States Virgin Islands; or
(e) any territory or insular possession subject to the jurisdiction of the United States.
(16) "Veterinary services" shall have the meaning provided for in Subsection 58-28-102(11).
(17)
(a) "Volunteer health practitioner" means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services.
(b) "Volunteer health practitioner" does not include a practitioner who receives compensation under a preexisting employment relationship with a host entity or affiliate that requires the practitioner to provide health services in Utah, unless the practitioner is:
(i) not a Utah resident; and
(ii) employed by a disaster relief organization providing services in Utah while an emergency declaration is in effect.

Amended by Chapter 295, 2013 General Session

26-49-103 Applicability to volunteer health practitioners.

This chapter applies to volunteer health practitioners who:
(1) are registered with a registration system that complies with Section 26-49-202; and
(2) provide health or veterinary services in Utah for a host entity while an emergency declaration is in effect.

Enacted by Chapter 242, 2008 General Session

Part 2
Regulation, Registration, and Licensing of Volunteer Health Practitioners - Administrative Sanctions

26-49-201 Regulation of services during emergency.

(1) While an emergency declaration is in effect, the Department of Health or a local health department may limit, restrict, or otherwise regulate:
  (a) the duration of practice by volunteer health practitioners;
  (b) the geographical areas in which volunteer health practitioners may practice;
  (c) the types of volunteer health practitioners who may practice; and
  (d) any other matters necessary to coordinate effectively the provision of health or veterinary services during the emergency.
(2) An order issued under Subsection (1) takes effect immediately, without prior notice or comment, and is not a rule within the meaning of Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or an adjudication within the meaning of Title 63G, Chapter 4, Administrative Procedures Act.
(3) A host entity that uses volunteer health practitioners to provide health or veterinary services in Utah shall:
  (a) to the extent practicable and in order to provide for the efficient and effective use of volunteer health practitioners, consult and coordinate its activities with:
    (i) the Department of Health;
    (ii) local health departments; or
    (iii) the Utah Department of Agriculture and Food;
  (b) comply with all state and federal laws relating to the management of emergency health or veterinary services.

Enacted by Chapter 242, 2008 General Session

26-49-202 Volunteer health practitioner registration systems.

(1) To qualify as a volunteer health practitioner registration system, the registration system shall:
  (a) accept applications for the registration of volunteer health practitioners before or during an emergency;
  (b) include information about the licensure and good standing of health practitioners that is accessible by authorized persons;
  (c) be capable of confirming the accuracy of information concerning whether a health practitioner is licensed and in good standing before health services or veterinary services are provided under this chapter; and
  (d) meet one of the following conditions:
    (i) be an emergency system for advance registration of volunteer health practitioners established by a state and funded through the United States Department of Health and Human Services under Section 319I of the Public Health Services Act, 42 U.S.C. Sec. 247d-7b, as amended;
    (ii) be a local unit consisting of trained and equipped emergency response, public health, and medical personnel formed under Section 2801 of the Public Health Services Act, 42 U.S.C. Sec. 300hh as amended;
    (iii) be operated by a:

(A) disaster relief organization;
(B) licensing board;
(C) national or regional association of licensing boards or health practitioners;
(D) health facility that provides comprehensive inpatient and outpatient healthcare services, including tertiary care; or
(E) governmental entity; or
(iv) be designated by the Department of Health as a registration system for purposes of this chapter.

(2)
(a) Subject to Subsection (2)(b), while an emergency declaration is in effect, the Department of Health, a person authorized to act on behalf of the Department of Health, or a host entity shall confirm whether a volunteer health practitioner in Utah is registered with a registration system that complies with Subsection (1).
(b) The confirmation authorized under this Subsection (2) is limited to obtaining the identity of the practitioner from the system and determining whether the system indicates that the practitioner is licensed and in good standing.

(3) Upon request of a person authorized under Subsection (2), or a similarly authorized person in another state, a registration system located in Utah shall notify the person of the identity of a volunteer health practitioner and whether or not the volunteer health practitioner is licensed and in good standing.

(4) A host entity is not required to use the services of a volunteer health practitioner even if the volunteer health practitioner is registered with a registration system that indicates that the practitioner is licensed and in good standing.

Amended by Chapter 297, 2011 General Session

26-49-203 Recognition of volunteer health practitioners licensed in other states.

(1) While an emergency declaration is in effect, a volunteer health practitioner registered with a registration system that complies with Section 26-49-202 and licensed and in good standing in the state upon which the practitioner's registration is based:
(a) may practice in Utah to the extent authorized by this chapter as if the practitioner were licensed in Utah; and
(b) is exempt from:
(i) licensure in Utah; or
(ii) operating under modified scope of practice provisions in accordance with Subsections 58-1-307(4) and (5).

(2) A volunteer health practitioner qualified under Subsection (1) is not entitled to the protections of this chapter if the practitioner is licensed in more than one state and any license of the practitioner:
(a) is suspended, revoked, or subject to an agency order limiting or restricting practice privileges; or
(b) has been voluntarily terminated under threat of sanction.

Enacted by Chapter 242, 2008 General Session

26-49-204 No effect on credentialing and privileging.

(1) For purposes of this section:

(a) "Credentialing" means obtaining, verifying, and assessing the qualifications of a health practitioner to provide treatment, care, or services.
(b) "Privileging" means the authorizing by an appropriate authority of a health practitioner to provide specific treatment, care, or services at a health facility subject to limits based on factors that include license, education, training, experience, competence, health status, and specialized skill.
(2) This chapter does not affect credentialing or privileging standards of a health facility, and does not preclude a health facility from waiving or modifying those standards while an emergency declaration is in effect.

Enacted by Chapter 242, 2008 General Session

26-49-205 Provision of volunteer health or veterinary services -- Administrative sanctions -- Authority of Division of Occupational and Professional Licensing.
(1) Subject to Subsections (2) and (3), a volunteer health practitioner shall comply with the scope of practice for a similarly licensed practitioner established by the licensing provisions, practice acts, or other Utah laws.
(2) Except as otherwise provided in Subsection (3), this chapter does not authorize a volunteer health practitioner to provide services that are outside the volunteer health practitioner's scope of practice, even if a similarly licensed practitioner in Utah would be permitted to provide the services.
(3)
(a) In accordance with this section and Section 58-1-405, the Division of Occupational and Professional Licensing may issue an order modifying or restricting the health or veterinary services that volunteer health practitioners may provide pursuant to this chapter.
(b) An order under this subsection takes effect immediately, without prior notice or comment, and is not a rule within the meaning of Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or a directive within the meaning of Title 63G, Chapter 4, Administrative Procedures Act.
(4) A host entity may restrict the health or veterinary services that a volunteer health practitioner may provide under this chapter.
(5)
(a) A volunteer health practitioner does not engage in unauthorized practice unless the volunteer health practitioner has reason to know of any limitation, modification, or restriction under this chapter, Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, or that a similarly licensed practitioner in Utah would not be permitted to provide the services.
(b) A volunteer health practitioner has reason to know of a limitation, modification, or restriction, or that a similarly licensed practitioner in Utah would not be permitted to provide a service, if:
(i) the volunteer health practitioner knows the limitation, modification, or restriction exists or that a similarly licensed practitioner in Utah would not be permitted to provide the service; or
(ii) from all the facts and circumstances known to the volunteer health practitioner at the relevant time, a reasonable person would conclude that:
(A) the limitation, modification, or restriction exists; or
(B) a similarly licensed practitioner in Utah would not be permitted to provide the service.
(6) In addition to the authority granted by law of Utah other than this chapter to regulate the conduct of volunteer health practitioners, the Division of Occupational and Professional Licensing Act or other disciplinary authority in Utah:
(a) may impose administrative sanctions upon a volunteer health practitioner licensed in Utah for conduct outside of Utah in response to an out-of-state emergency;

(b) may impose administrative sanctions upon a volunteer health practitioner not licensed in Utah for conduct in Utah in response to an in-state emergency; and
(c) shall report any administrative sanctions imposed upon a volunteer health practitioner licensed in another state to the appropriate licensing board or other disciplinary authority in any other state in which the volunteer health practitioner is known to be licensed.
(7) In determining whether or not to impose administrative sanctions under Subsection (6), the Division of Occupational and Professional Licensing Act or other disciplinary authority shall consider the circumstances in which the conduct took place, including:
(a) any exigent circumstances; and
(b) the volunteer health practitioner's scope of practice, education, training, experience, and specialized skill.

Enacted by Chapter 242, 2008 General Session

Part 3
Relation to Other Laws

26-49-301 Relation to other laws.
(1)
(a) This chapter does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this chapter.
(b) Except as otherwise provided in Subsection (2), this chapter does not affect requirements for the use of health practitioners pursuant to Title 53, Chapter 2a, Part 4, Emergency Management Assistance Compact.
(2) An authorized representative of a party state may incorporate volunteer health practitioners into the emergency forces of Utah even if those volunteer health practitioners are not officers or employees of Utah, a political subdivision of Utah, or a municipality or other local government within Utah.

Enacted by Chapter 242, 2008 General Session

Part 4
Regulatory Authority

26-49-401 Regulatory authority.
(1) The Department of Health shall make rules by following the procedures and requirements of Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(2) Before adopting rules under Subsection (1), the Department of Health shall consult and consider:
(a) the recommendations of the entity established to coordinate the implementation of the Emergency Management Assistance Compact; and
(b) rules adopted by similarly empowered agencies in other states in order to promote uniformity of application of this chapter and make the emergency response systems in the various states reasonably compatible.

Enacted by Chapter 242, 2008 General Session

Part 5
Limitations on Civil Liability

26-49-501 Limitations on civil liability for volunteer health practitioners.

Volunteer health practitioners who provide health or veterinary services pursuant to this chapter are immune from liability and civil damages as set forth in Section 58-13-2.

Enacted by Chapter 242, 2008 General Session

Part 6
Workers' Compensation Coverage

26-49-601 Workers' compensation coverage.

(1) For purposes of this section, "injury" means a physical or mental injury or disease for which an employee of Utah who is injured or contracts the disease in the course of the employee's employment would be entitled to benefits under Title 34A, Chapter 2, Workers' Compensation Act.

(2) A volunteer health practitioner is considered a state employee for purposes of receiving workers' compensation medical benefits under Title 34A, Chapter 2, Workers' Compensation Act, and Chapter 3, Utah Occupational Disease Act.

(3) The state shall provide workers' compensation benefits for a volunteer health practitioner under:

(a) Title 34A, Chapter 2, Workers' Compensation Act; and

(b) Title 34A, Chapter 3, Utah Occupational Disease Act.

(4)

(a) In accordance with Section 34A-2-105, the workers' compensation benefits described in Subsection (3) are the exclusive remedy against the state or an officer, agent, or employee of the state, for all injuries and occupational diseases resulting from the volunteer health practitioner's services for the state.

(b) For purposes of Subsection (4)(a), the state is considered the employer of the volunteer health practitioner.

(5) To compute the workers' compensation benefits for a volunteer health practitioner described in Subsection (3), the average weekly wage of the volunteer health practitioner shall be the state's average weekly wage at the time of the emergency that is the basis for the volunteer health practitioner's workers' compensation claim.

(6)

(a) The Labor Commission shall:

(i) adopt rules, enter into agreements with other states, or take other measures to facilitate the receipt of benefits for injury or death by volunteer health practitioners who reside in other states; and

(ii) consult with and consider the practices for filing, processing, and paying claims by agencies with similar authority in other states to promote uniformity of application of this chapter with other states that enact similar legislation.

(b) The Labor Commission may waive or modify requirements for filing, processing, and paying claims that unreasonably burden the volunteer health practitioners.

Enacted by Chapter 242, 2008 General Session

Part 7
Uniformity of Application and Construction

26-49-701 Uniformity of application and construction.

In applying and construing this chapter, consideration shall be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

Amended by Chapter 297, 2011 General Session

Chapter 50
Traumatic Brain Injury Fund

Part 1
General Provisions

26-50-101 Title.

This chapter is known as the "Traumatic Brain Injury Fund."

Enacted by Chapter 325, 2008 General Session

26-50-102 Definitions.

As used in this chapter:

(1) "Committee" means the advisory committee created by the executive director pursuant to Section 26-50-202.

(2) "Fund" means the Traumatic Brain Injury Fund created in Section 26-50-201.

Enacted by Chapter 325, 2008 General Session

Part 2
Traumatic Brain Injury Fund

26-50-201 Traumatic Brain Injury Fund.

(1) There is created an expendable special revenue fund entitled the Traumatic Brain Injury Fund.

(2) The fund shall consist of:

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

(b) additional amounts as appropriated by the Legislature.

(3) The fund shall be administered by the executive director.

(4) Fund money may be used to:
(a) educate the general public and professionals regarding understanding, treatment, and prevention of traumatic brain injury;
(b) provide access to evaluations and coordinate short-term care to assist an individual in identifying services or support needs, resources, and benefits for which the individual may be eligible;
(c) develop and support an information and referral system for persons with a traumatic brain injury and their families; and
(d) provide grants to persons or organizations to provide the services described in Subsections (4)(a), (b), and (c).
(5) Not less that 50% of the fund shall be used each fiscal year to directly assist individuals who meet the qualifications described in Subsection (6).
(6) An individual who receives services either paid for from the fund, or through an organization under contract with the fund, shall:
(a) be a resident of Utah;
(b) have been diagnosed by a qualified professional as having a traumatic brain injury which results in impairment of cognitive or physical function; and
(c) have a need that can be met within the requirements of this chapter.
(7) The fund may not duplicate any services or support mechanisms being provided to an individual by any other government or private agency.
(8) All actual and necessary operating expenses for the committee and staff shall be paid by the fund.
(9) The fund may not be used for medical treatment, long-term care, or acute care.

Amended by Chapter 400, 2013 General Session

26-50-202 Traumatic Brain Injury Advisory Committee -- Membership -- Time limit.
(1) On or after July 1 of each year, the executive director may create a Traumatic Brain Injury Advisory Committee of not more than nine members.
(2) The committee shall be composed of members of the community who are familiar with traumatic brain injury, its causes, diagnosis, treatment, rehabilitation, and support services, including:
(a) persons with a traumatic brain injury;
(b) family members of a person with a traumatic brain injury;
(c) representatives of an association which advocates for persons with traumatic brain injuries;
(d) specialists in a profession that works with brain injury patients; and
(e) department representatives.
(3) The department shall provide staff support to the committee.
(4)
(a) If a vacancy occurs in the committee membership for any reason, a replacement may be appointed for the unexpired term.
(b) The committee shall elect a chairperson from the membership.
(c) A majority of the committee constitutes a quorum at any meeting, and, if a quorum exists, the action of the majority of members present shall be the action of the committee.
(d) The committee may adopt bylaws governing the committee's activities.
(e) A committee member may be removed by the executive director:
(i) if the member is unable or unwilling to carry out the member's assigned responsibilities; or
(ii) for good cause.

(5) The committee shall comply with the procedures and requirements of:
(a)Title 52, Chapter 4, Open and Public Meetings Act; and
(b)Title 63G, Chapter 2, Government Records Access and Management Act.
(6) A member may not receive compensation or benefits for the member's service, but, at the executive director's discretion, 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.
(7) Not later than November 30 of each year the committee shall provide a written report summarizing the activities of the committee to:
(a) the executive director of the department; and
(b) the Social Services Appropriations Subcommittee.
(8) The committee shall cease to exist on December 31 of each year, unless the executive director determines it necessary to continue.

Amended by Chapter 168, 2016 General Session

Chapter 51
Methamphetamine Decontamination Act

Part 1
General Provisions

26-51-101 Title.
This chapter is known as the "Methamphetamine Decontamination Act."

Enacted by Chapter 38, 2008 General Session

Part 2
Methamphetamine Decontamination

26-51-201 Scientific standards for methamphetamine decontamination.
(1) The department shall make rules adopting scientifically-based standards for methamphetamine decontamination.
(2) A local health department, as defined in Title 26A, Local Health Authorities, shall follow rules made by the department under Subsection (1) in administering Title 19, Chapter 6, Part 9, Illegal Drug Operations Site Reporting and Decontamination Act.

Enacted by Chapter 38, 2008 General Session

26-51-202 Public education concerning methamphetamine contamination.
The department shall conduct a public education campaign to inform the public about potential health risks of methamphetamine contamination.

Enacted by Chapter 38, 2008 General Session

Chapter 53
Protection of Athletes with Head Injuries Act

Part 1
General Provisions

26-53-101 Title.

This chapter is known as the "Protection of Athletes With Head Injuries Act."

Enacted by Chapter 97, 2011 General Session

26-53-102 Definitions.

As used in this chapter:

(1) "Agent" means a coach, teacher, employee, representative, or volunteer.

(2)

(a) "Amateur sports organization" means, except as provided in Subsection (2)(b):

(i) a sports team;

(ii) a public or private school;

(iii) a public or private sports league;

(iv) a public or private sports camp; or

(v) any other public or private organization that organizes, manages, or sponsors a sporting event for its members, enrollees, or attendees.

(b) "Amateur sports organization" does not include a professional:

(i) team;

(ii) league; or

(iii) sporting event.

(3) "Child" means an individual who is under the age of 18.

(4) "Qualified health care provider" means a health care provider who:

(a) is licensed under Title 58, Occupations and Professions; and

(b) may evaluate and manage a concussion within the health care provider's scope of practice.

(5)

(a) "Sporting event" means any of the following athletic activities that is organized, managed, or sponsored by an organization:

(i) a game;

(ii) a practice;

(iii) a sports camp;

(iv) a physical education class;

(v) a competition; or

(vi) a tryout.

(b) "Sporting event" does not include:

(i) the issuance of a lift ticket or pass by a ski resort, the use of the ticket or pass, or a ski or snowboarding class or school at a ski resort, unless the skiing or snowboarding is part of a camp, team, or competition that is organized, managed, or sponsored by the ski resort;

(ii) as applied to a government entity, merely making available a field, facility, or other location owned, leased, or controlled by the government entity to an amateur sports organization or a child, regardless of whether the government entity charges a fee for the use; or
(iii) free play or recess taking place during school hours.
(6) "Traumatic head injury" means an injury to the head arising from blunt trauma, an acceleration force, or a deceleration force, with one of the following observed or self-reported conditions attributable to the injury:
(a) transient confusion, disorientation, or impaired consciousness;
(b) dysfunction of memory;
(c) loss of consciousness; or
(d) signs of other neurological or neuropsychological dysfunction, including:
(i) seizures;
(ii) irritability;
(iii) lethargy;
(iv) vomiting;
(v) headache;
(vi) dizziness; or
(vii) fatigue.

Amended by Chapter 18, 2013 General Session

Part 2
Concussion and Head Injury Policy

26-53-201 Adoption and enforcement of concussion and head injury policy -- Notice of policy to parent or guardian.

Each amateur sports organization shall:
(1) adopt and enforce a concussion and head injury policy that:
(a) is consistent with the requirements of Section 26-53-301; and
(b) describes the nature and risk of:
(i) a concussion or a traumatic head injury; and
(ii) continuing to participate in a sporting event after sustaining a concussion or a traumatic head injury;
(2) ensure that each agent of the amateur sports organization is familiar with, and has a copy of, the concussion and head injury policy; and
(3) before permitting a child to participate in a sporting event of the amateur sports organization:
(a) provide a written copy of the concussion and head injury policy to a parent or legal guardian of a child; and
(b) obtain the signature of a parent or legal guardian of the child, acknowledging that the parent or legal guardian has read, understands, and agrees to abide by, the concussion and head injury policy.

Enacted by Chapter 97, 2011 General Session

Part 3

Medical Clearance

26-53-301 Removal of child suspected of sustaining concussion or a traumatic head injury -- Medical clearance required before return to participation.

(1) An amateur sports organization, and each agent of the amateur sports organization, shall:
  (a) immediately remove a child from participating in a sporting event of the amateur sports organization if the child is suspected of sustaining a concussion or a traumatic head injury; and
  (b) prohibit the child described in Subsection (1)(a) from participating in a sporting event of the amateur sports organization until the child:
    (i) is evaluated by a qualified health care provider who is trained in the evaluation and management of a concussion; and
    (ii) provides the amateur sports organization with a written statement from the qualified health care provider described in Subsection (1)(b)(i) stating that:
      (A) the qualified health care provider has, within three years before the day on which the written statement is made, successfully completed a continuing education course in the evaluation and management of a concussion; and
      (B) the child is cleared to resume participation in the sporting event of the amateur sports organization.
(2) This section does not create a new cause of action.

Enacted by Chapter 97, 2011 General Session

Part 4
Student Injury Evaluation

26-53-401 School nurses evaluating student injuries.

(1) A school nurse may assess a child who is suspected of sustaining a concussion or a traumatic head injury during school hours on school property regardless of whether the nurse has received specialized training in the evaluation and management of a concussion.
(2) A school nurse who does not meet the requirements of Subsections 26-53-301(1)(b)(i) and (1)(b)(ii)(A), but who assesses a child who is suspected of sustaining a concussion or traumatic head injury under Subsection (1):
  (a) shall refer the child to a qualified health care provider who is trained in the evaluation and management of a concussion; and
  (b) may not provide a written statement permitting the child to resume participation in free play or physical education class under Subsection 26-53-301(1)(b)(ii).
(3) A school nurse shall undergo training in the evaluation and management of a concussion, as funding allows.

Amended by Chapter 165, 2014 General Session

Chapter 54

Spinal Cord and Brain Injury Rehabilitation Fund and Pediatric Neuro-rehabilitation Fund

26-54-101 Title.

This chapter is known as the "Spinal Cord and Brain Injury Rehabilitation Fund and Pediatric Neuro-Rehabilitation Fund."

Amended by Chapter 405, 2019 General Session

26-54-102 Spinal Cord and Brain Injury Rehabilitation Fund -- Creation -- Administration -- Uses.

(1) As used in this section, a "qualified IRC 501(c)(3) charitable clinic" means a professional medical clinic that:
  (a) provides rehabilitation services to individuals in the state:
    (i) who have a traumatic spinal cord or brain injury that tends to be nonprogressive or nondeteriorating; and
    (ii) who require post-acute care;
  (b) employs licensed therapy clinicians;
  (c) has at least five years experience operating a post-acute care rehabilitation clinic in the state; and
  (d) has obtained tax-exempt status under Internal Revenue Code, 26 U.S.C. Sec. 501(c)(3).
(2) There is created an expendable special revenue fund known as the "Spinal Cord and Brain Injury Rehabilitation Fund."
(3) The fund shall consist of:
  (a) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;
  (b) a portion of the impound fee as designated in Section 41-6a-1406;
  (c) the fees collected by the Motor Vehicle Division under Subsections 41-1a-1201(9) and 41-22-8(3); and
  (d) amounts appropriated by the Legislature.
(4) The fund shall be administered by the executive director of the department, in consultation with the advisory committee created in Section 26-54-103.
(5) Fund money shall be used to:
  (a) assist one or more qualified IRC 501(c)(3) charitable clinics to provide rehabilitation services to individuals who have a traumatic spinal cord or brain injury that tends to be nonprogressive or nondeteriorating, including:
    (i) physical, occupational, and speech therapy; and
    (ii) equipment for use in the qualified charitable clinic; and
  (b) pay for operating expenses of the advisory committee created by Section 26-54-103, including the advisory committee's staff.

Amended by Chapter 405, 2019 General Session

26-54-102.5 Pediatric Neuro-Rehabilitation Fund -- Creation -- Administration -- Uses.

(1) As used in this section, a "qualified IRC 501(c)(3) charitable clinic" means a professional medical clinic that:
  (a) provides services for children in the state:

(i) with neurological conditions, including:
(A) cerebral palsy; and
(B) spina bifida; and
(ii) who require post-acute care;
(b) employs licensed therapy clinicians;
(c) has at least five years experience operating a post-acute care rehabilitation clinic in the state; and
(d) has obtained tax-exempt status under Internal Revenue Code, 26 U.S.C. Sec. 501(c)(3).
(2) There is created an expendable special revenue fund known as the "Pediatric Neuro-Rehabilitation Fund."
(3) The fund shall consist of:
(a) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources; and
(b) amounts appropriated to the fund by the Legislature.
(4) The fund shall be administered by the executive director of the department, in consultation with the advisory committee created in Section 26-54-103.
(5) Fund money shall be used to:
(a) assist one or more qualified IRC 501(c)(3) charitable clinics to provide physical or occupational therapy to children with neurological conditions; and
(b) pay for operating expenses of the advisory committee created by Section 26-54-103, including the advisory committee's staff.

Enacted by Chapter 405, 2019 General Session

26-54-103 Spinal Cord and Brain Injury Rehabilitation Fund and Pediatric Neuro-Rehabilitation Fund Advisory Committee -- Creation -- Membership -- Terms -- Duties.
(1) There is created a Spinal Cord and Brain Injury Rehabilitation Fund and Pediatric Neuro-Rehabilitation Fund Advisory Committee.
(2) The advisory committee shall be composed of 11 members as follows:
(a) the executive director, or the executive director's designee;
(b) two survivors, or family members of a survivor, of a traumatic brain injury appointed by the governor;
(c) two survivors, or family members of a survivor, of a traumatic spinal cord injury appointed by the governor;
(d) one traumatic brain injury or spinal cord injury professional appointed by the governor who, at the time of appointment and throughout the professional's term on the committee, does not receive a financial benefit from the fund;
(e) two parents of a child with a nonprogressive neurological condition appointed by the governor;
(f)
(i) a physical therapist licensed under Title 58, Chapter 24b, Physical Therapy Practice Act, with experience treating brain and spinal cord injuries, appointed by the governor; or
(ii) an occupational therapist licensed under Title 58, Chapter 42a, Occupational Therapy Practice Act, with experience treating brain and spinal cord injuries, appointed by the governor;
(g) a member of the House of Representatives appointed by the speaker of the House of Representatives; and
(h) a member of the Senate appointed by the president of the Senate.

(3)
(a) The term of advisory committee members shall be four years. If a vacancy occurs in the committee membership for any reason, a replacement shall be appointed for the unexpired term in the same manner as the original appointment.
(b) The committee shall elect a chairperson from the membership.
(c) A majority of the committee constitutes a quorum at any meeting, and, if a quorum is present at an open meeting, the action of the majority of members shall be the action of the advisory committee.
(d) The terms of the advisory committee shall be staggered so that members appointed under Subsections (2)(b), (d), and (f) shall serve an initial two-year term and members appointed under Subsections (2)(c), (e), and (g) shall serve four-year terms. Thereafter, members appointed to the advisory committee shall serve four-year terms.
(4) The advisory committee shall comply with the procedures and requirements of:
(a)Title 52, Chapter 4, Open and Public Meetings Act;
(b)Title 63G, Chapter 2, Government Records Access and Management Act; and
(c)Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(5)
(a) A member who is not a legislator may not receive compensation or benefits for the member's service, but, at the executive director's discretion, may receive per diem and travel expenses as allowed in:
(i) Section 63A-3-106;
(ii) Section 63A-3-107; and
(iii) rules adopted by the Division of Finance according to Sections 63A-3-106 and 63A-3-107.
(b) Compensation and expenses of a member who is a legislator are governed by Section 36-2-2 and Legislative Joint Rules, Title 5, Legislative Compensation and Expenses.
(6) The advisory committee shall:
(a) adopt rules and procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish priorities and criteria for the advisory committee to follow in recommending distribution of money from the fund to assist qualified IRC 501(c)(3) charitable clinics, as defined in Sections 26-54-102 and 26-54-102.5;
(b) identify, evaluate, and review the quality of care available to:
(i) individuals with spinal cord and brain injuries through qualified IRC 501(c)(3) charitable clinics, as defined in Section 26-54-102; or
(ii) children with nonprogressive neurological conditions through qualified IRC 501(c)(3) charitable clinics, as defined in Section 26-54-102.5;
(c) explore, evaluate, and review other possible funding sources and make a recommendation to the Legislature regarding sources that would provide adequate funding for the advisory committee to accomplish its responsibilities under this section; and
(d) submit an annual report, not later than November 30 of each year, summarizing the activities of the advisory committee and making recommendations regarding the ongoing needs of individuals with spinal cord or brain injuries and children with nonprogressive neurological conditions to:
(i) the governor;
(ii) the Health and Human Services Interim Committee; and
(iii) the Social Services Appropriations Subcommittee.
(7) Operating expenses for the advisory committee, including the committee's staff, shall be paid for only with money from:
(a) the Spinal Cord and Brain Injury Rehabilitation Fund;

(b) the Pediatric Neuro-Rehabilitation Fund; or
(c) both funds.

Amended by Chapter 405, 2019 General Session

Chapter 55
Opiate Overdose Response Act

26-55-101 Title.
This chapter is known as the " Opiate Overdose Response Act."

Amended by Chapter 202, 2016 General Session
Amended by Chapter 207, 2016 General Session
Amended by Chapter 208, 2016 General Session

26-55-102 Definitions.
As used in this chapter:
(1) "Controlled substance" means the same as that term is defined in Title 58, Chapter 37, Utah Controlled Substances Act.
(2) "Dispense" means the same as that term is defined in Section 58-17b-102.
(3) "Health care facility" means a hospital, a hospice inpatient residence, a nursing facility, a dialysis treatment facility, an assisted living residence, an entity that provides home- and community-based services, a hospice or home health care agency, or another facility that provides or contracts to provide health care services, which facility is licensed under Chapter 21, Health Care Facility Licensing and Inspection Act.
(4) "Health care provider" means:
(a) a physician, as defined in Section 58-67-102;
(b) an advanced practice registered nurse, as defined in Section 58-31b-102;
(c) a physician assistant, as defined in Section 58-70a-102; or
(d) an individual licensed to engage in the practice of dentistry, as defined in Section 58-69-102.
(5) "Increased risk" means risk exceeding the risk typically experienced by an individual who is not using, and is not likely to use, an opiate.
(6) "Local health department" means:
(a) a local health department, as defined in Section 26A-1-102; or
(b) a multicounty local health department, as defined in Section 26A-1-102.
(7) "Opiate" means the same as that term is defined in Section 58-37-2.
(8) "Opiate antagonist" means naloxone hydrochloride or any similarly acting drug that is not a controlled substance and that is approved by the federal Food and Drug Administration for the diagnosis or treatment of an opiate-related drug overdose.
(9) "Opiate-related drug overdose event" means an acute condition, including a decreased level of consciousness or respiratory depression resulting from the consumption or use of a controlled substance, or another substance with which a controlled substance was combined, and that a person would reasonably believe to require medical assistance.
(10) "Overdose outreach provider" means:
(a) a law enforcement agency;
(b) a fire department;

(c) an emergency medical service provider, as defined in Section 26-8a-102;
(d) emergency medical service personnel, as defined in Section 26-8a-102;
(e) an organization providing treatment or recovery services for drug or alcohol use;
(f) an organization providing support services for an individual, or a family of an individual, with a substance use disorder;
(g) an organization providing substance use or mental health services under contract with a local substance abuse authority, as defined in Section 62A-15-102, or a local mental health authority, as defined in Section 62A-15-102;
(h) an organization providing services to the homeless;
(i) a local health department;
(j) an individual licensed to practice pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act; or
(k) an individual.
(11) "Patient counseling" means the same as that term is defined in Section 58-17b-102.
(12) "Pharmacist" means the same as that term is defined in Section 58-17b-102.
(13) "Pharmacy intern" means the same as that term is defined in Section 58-17b-102.
(14) "Prescribe" means the same as that term is defined in Section 58-17b-102.

Amended by Chapter 392, 2017 General Session

26-55-103 Voluntary participation.

This chapter does not create a duty or standard of care for a person to prescribe or administer an opiate antagonist.

Enacted by Chapter 130, 2014 General Session

26-55-104 Prescribing, dispensing, and administering an opiate antagonist -- Immunity from liability.

(1)
(a)
(i) For purposes of Subsection (1)(a)(ii), "a person other than a health care facility or health care provider" includes the following, regardless of whether the person has received funds from the department through the Opiate Overdose Outreach Pilot Program created in Section 26-55-107:
(A) a person described in Subsections 26-55-107(1)(a)(i)(A) through (1)(a)(i)(F); or
(B) an organization, defined by department rule made under Subsection 26-55-107(7)(e), that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event.
(ii) Except as provided in Subsection (1)(b), the following persons are not liable for any civil damages for acts or omissions made as a result of administering an opiate antagonist when the person acts in good faith to administer the opiate antagonist to an individual whom the person believes to be experiencing an opiate-related drug overdose event:
(A) an overdose outreach provider; or
(B) a person other than a health care facility or health care provider.
(b) A health care provider:
(i) is not immune from liability under Subsection (1)(a) when the health care provider is acting within the scope of the health care provider's responsibilities or duty of care; and

(ii) is immune from liability under Subsection (1)(a) if the health care provider is under no legal duty to respond and otherwise complies with Subsection (1)(a).

(2) Notwithstanding Sections 58-1-501, 58-17b-501, and 58-17b-502, a health care provider who is licensed to prescribe an opiate antagonist may prescribe, including by a standing prescription drug order issued in accordance with Subsection 26-55-105(2), or dispense an opiate antagonist:

(a)

(i) to an individual who is at increased risk of experiencing an opiate-related drug overdose event;

(ii) for an individual described in Subsection (2)(a)(i), to a family member, friend, or other person, including a person described in Subsections 26-55-107(1)(a)(i)(A) through (1)(a)(i)(F), that is in a position to assist the individual; or

(iii) to an overdose outreach provider for:

(A) furnishing the opiate antagonist to an individual described in Subsection (2)(a)(i) or (ii), as provided in Section 26-55-106; or

(B) administering to an individual experiencing an opiate-related drug overdose event;

(b) without a prescriber-patient relationship; and

(c) without liability for any civil damages for acts or omissions made as a result of prescribing or dispensing the opiate antagonist in good faith.

(3) A health care provider who dispenses an opiate antagonist to an individual or an overdose outreach provider under Subsection (2)(a) shall provide education to the individual or overdose provider that includes written instruction on how to:

(a) recognize an opiate-related drug overdose event; and

(b) respond appropriately to an opiate-related drug overdose event, including how to:

(i) administer an opiate antagonist; and

(ii) ensure that an individual to whom an opiate antagonist has been administered receives, as soon as possible, additional medical care and a medical evaluation.

Amended by Chapter 181, 2017 General Session
Amended by Chapter 392, 2017 General Session

26-55-105 Standing prescription drug orders for an opiate antagonist.

(1) Notwithstanding Title 58, Chapter 17b, Pharmacy Practice Act, a person licensed under Title 58, Chapter 17b, Pharmacy Practice Act, to dispense an opiate antagonist may dispense the opiate antagonist:

(a) pursuant to a standing prescription drug order made in accordance with Subsection (2); and

(b) without any other prescription drug order from a person licensed to prescribe an opiate antagonist.

(2) A physician who is licensed to prescribe an opiate antagonist, including a physician acting in the physician's capacity as an employee of the department, or a medical director of a local health department, as defined in Section 26A-1-102, may issue a standing prescription drug order authorizing the dispensing of the opiate antagonist under Subsection (1) in accordance with a protocol that:

(a) limits dispensing of the opiate antagonist to:

(i) an individual who is at increased risk of experiencing an opiate-related drug overdose event;

(ii) a family member of, friend of, or other person, including a person described in Subsections 26-55-107(1)(a)(i)(A) through (1)(a)(i)(F), that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; or

(iii) an overdose outreach provider for:
(A) furnishing to an individual who is at increased risk of experiencing an opiate-related drug overdose event, or to a family member of, friend of, or other individual who is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event, as provided in Section 26-55-106; or
(B) administering to an individual experiencing an opiate-related drug overdose event;
(b) requires the physician to specify the persons, by professional license number, authorized to dispense the opiate antagonist;
(c) requires the physician to review at least annually the dispensing practices of those authorized by the physician to dispense the opiate antagonist;
(d) requires those authorized by the physician to dispense the opiate antagonist to make and retain a record of each person to whom the opiate antagonist is dispensed, which shall include:
(i) the name of the person;
(ii) the drug dispensed; and
(iii) other relevant information; and
(e) is approved by the Division of Occupational and Professional Licensing within the Department of Commerce by administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Amended by Chapter 202, 2016 General Session, (Coordination Clause)
Enacted by Chapter 208, 2016 General Session

26-55-106 Overdose outreach providers.

Notwithstanding Sections 58-1-501, 58-17b-501, and 58-17b-502:
(1) an overdose outreach provider may:
(a) obtain an opiate antagonist dispensed on prescription by:
(i) a health care provider, in accordance with Subsections 26-55-104(2) and (3); or
(ii) a pharmacist or pharmacy intern, as otherwise authorized by Title 58, Chapter 17b, Pharmacy Practice Act;
(b) store the opiate antagonist; and
(c) furnish the opiate antagonist:
(i)
(A) to an individual who is at increased risk of experiencing an opiate-related drug overdose event; or
(B) to a family member, friend, overdose outreach provider, or other individual who is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; and
(ii) without liability for any civil damages for acts or omissions made as a result of furnishing the opiate antagonist in good faith; and
(2) when furnishing an opiate antagonist under Subsection (1), an overdose outreach provider:
(a) shall also furnish to the recipient of the opiate antagonist:
(i) the written instruction under Subsection 26-55-104(3) received by the overdose outreach provider from the health care provider at the time the opiate antagonist was dispensed to the overdose outreach provider; or
(ii) if the opiate antagonist was dispensed to the overdose outreach provider by a pharmacist or pharmacy intern, any written patient counseling under Section 58-17b-613 received by the overdose outreach provider at the time of dispensing; and

(b) may provide additional instruction on how to recognize and respond appropriately to an opiate-related drug overdose event.

Amended by Chapter 392, 2017 General Session

26-55-107 Opiate Overdose Outreach Pilot Program -- Grants -- Annual reporting by grantees -- Rulemaking -- Annual reporting by department.

(1) As used in this section:

(a) "Persons that are in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event":

(i) means the following organizations:

(A) a law enforcement agency;

(B) the department or a local health department, as defined in Section 26A-1-102;

(C) an organization that provides drug or alcohol treatment services;

(D) an organization that provides services to the homeless;

(E) an organization that provides training on the proper administration of an opiate antagonist in response to an opiate-related drug overdose event;

(F) a school; or

(G) except as provided in Subsection (1)(a)(ii), any other organization, as defined by department rule made under Subsection (7)(e), that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event; and

(ii) does not mean:

(A) a person licensed under Title 58, Chapter 17b, Pharmacy Practice Act;

(B) a health care facility; or

(C) an individual.

(b) "School" means:

(i) a public school:

(A) for elementary or secondary education, including a charter school; or

(B) for other purposes;

(ii) a private school:

(A) for elementary or secondary education; or

(B) accredited for other purposes, including higher education or specialty training; or

(iii) an institution within the state system of higher education, as described in Section 53B-1-102.

(2) There is created within the department the "Opiate Overdose Outreach Pilot Program."

(3) The department may use funds appropriated for the program to:

(a) provide grants under Subsection (4);

(b) promote public awareness of the signs, symptoms, and risks of opioid misuse and overdose;

(c) increase the availability of educational materials and other resources designed to assist individuals at increased risk of opioid overdose, their families, and others in a position to help prevent or respond to an overdose event;

(d) increase public awareness of, access to, and use of opiate antagonist;

(e) update the department's Utah Clinical Guidelines on Prescribing Opioids and promote its use by prescribers and dispensers of opioids;

(f) develop a directory of substance misuse treatment programs and promote its dissemination to and use by opioid prescribers, dispensers, and others in a position to assist individuals at increased risk of opioid overdose;

(g) coordinate a multi-agency coalition to address opioid misuse and overdose; and

(h) maintain department data collection efforts designed to guide the development of opioid overdose interventions and track their effectiveness.

(4) No later than September 1, 2016, and with available funding, the department shall grant funds through the program to persons that are in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event.

(5) Funds granted by the program:

(a) may be used by a grantee to:

(i) pay for the purchase by the grantee of an opiate antagonist; or

(ii) pay for the grantee's cost of providing training on the proper administration of an opiate antagonist in response to an opiate-related drug overdose event; and

(b) may not be used:

(i) to pay for costs associated with the storage or dispensing of an opiate antagonist; or

(ii) for any other purposes.

(6) Grantees shall report annually to the department on the use of granted funds in accordance with department rules made under Subsection (7)(d).

(7) No later than July 1, 2016, the department shall, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, make rules specifying:

(a) how to apply for a grant from the program;

(b) the criteria used by the department to determine whether a grant request is approved, including criteria providing that:

(i) grants are awarded to areas of the state, including rural areas, that would benefit most from the grant; and

(ii) no more than 15% of the total amount granted by the program is used to pay for grantees' costs of providing training on the proper administration of an opiate antagonist in response to an opiate-related drug overdose event;

(c) the criteria used by the department to determine the amount of a grant;

(d) the information a grantee shall report annually to the department under Subsection (6), including:

(i) the amount of opiate antagonist purchased and dispensed by the grantee during the reporting period;

(ii) the number of individuals to whom the opiate antagonist was dispensed by the grantee;

(iii) the number of lives known to have been saved during the reporting period as a result of opiate antagonist dispensed by the grantee; and

(iv) the manner in which the grantee shall record, preserve, and make available for audit by the department the information described in Subsections (7)(d)(i) through (7)(d)(iii); and

(e) as required by Subsection (1)(a)(i)(G), any other organization that is in a position to assist an individual who is at increased risk of experiencing an opiate-related drug overdose event.

(8) The department shall report to the Legislature's Social Services Appropriations Subcommittee no later than September 1 of each year on the outcomes of the Opiate Overdose Outreach Pilot Program.

Enacted by Chapter 202, 2016 General Session
Amended by Chapter 207, 2016 General Session, (Coordination Clause)

26-55-108 Coprescription guidelines.

(1) As used in this section:

(a) "Controlled substance prescriber" means the same as that term is defined in Section 58-37-6.5.

(b) "Coprescribe" means to issue a prescription for an opiate antagonist with a prescription for an opiate.
(2) The department shall, in consultation with the Physicians Licensing Board created in Section 58-67-201, the Osteopathic Physician and Surgeon's Licensing Board created in Section 58-68-201, and the Department of Occupational and Professional Licensing created in Section 58-1-103, establish by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, scientifically based guidelines for controlled substance prescribers to coprescribe an opiate antagonist to a patient.

Amended by Chapter 38, 2018 General Session

26-55-109 Opiate abuse prevention pamphlet.
(1) As funding is available, the department shall produce and distribute, in conjunction with the Division of Substance Abuse and Mental Health, a pamphlet about opiates that includes information regarding:
(a) the risk of dependency and addiction;
(b) methods for proper storage and disposal;
(c) alternative options for pain management;
(d) the benefits of and ways to obtain naloxone; and
(e) resources if the patient believes that the patient has a substance abuse disorder.
(2) The pamphlet described in Subsection (1) shall be:
(a) evaluated periodically for effectiveness at conveying necessary information and revised accordingly;
(b) written in simple and understandable language; and
(c) available in English and other languages that the department determines to be appropriate and necessary.

Enacted by Chapter 145, 2018 General Session

Chapter 57
Electronic Cigarette Regulation Act

26-57-101 Title.
This chapter is known as the "Electronic Cigarette Regulation Act."

Enacted by Chapter 132, 2015 General Session

26-57-102 Definitions.
As used in this chapter:
(1) "Cigarette" means the same as that term is defined in Section 59-14-102.
(2) "Electronic cigarette" means the same as that term is defined in Section 59-14-802.
(3) "Electronic cigarette product" means an electronic cigarette or an electronic cigarette substance.
(4) "Electronic cigarette substance" means the same as that term is defined in Section 59-14-802.
(5) "Manufacture" includes:
(a) to cast, construct, or make electronic cigarettes; or

(b) to blend, make, process, or prepare an electronic cigarette substance.
(6) "Manufacturer sealed electronic cigarette substance" means an electronic cigarette substance that is sold in a container that:
(a) is pre-filled by the electronic cigarette substance manufacturer; and
(b) the electronic cigarette manufacturer does not intend for a consumer to open.

Enacted by Chapter 132, 2015 General Session

26-57-103 Electronic cigarette products -- Labeling -- Manufacturing and quality control standards -- Advertising.
(1) The department shall, in consultation with a local health department, as defined in Section 26A-1-102, and with input from members of the public, establish, no later than January 1, 2016, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, standards for electronic cigarette substance:
(a) labeling;
(b) nicotine content;
(c) packaging; and
(d) product quality.
(2) The standards established by the department under Subsection (1) do not apply to a manufacturer sealed electronic cigarette substance.
(3) Beginning on July 1, 2016, a person may not sell an electronic cigarette substance unless the electronic cigarette substance complies with the standards established by the department under Subsection (1).
(4)
(a) Beginning on July 1, 2016, a local health department may not enact a rule or regulation regarding electronic cigarette substance labeling, nicotine content, packaging, or product quality that is not identical to the standards established by the department under Subsection (1).
(b) Except as provided in Subsection (4)(c), a local health department may enact a rule or regulation regarding electronic cigarette substance manufacturing.
(c) A local health department may not enact a rule or regulation regarding a manufacturer sealed electronic cigarette substance.
(5) Beginning on July 1, 2016, a person may not advertise an electronic cigarette product:
(a) as a tobacco cessation device;
(b) if the person is not licensed to sell an electronic cigarette product under Section 59-14-803; or
(c) during a period of time when the person's license to sell an electronic cigarette product under Section 59-14-803 has been suspended or revoked.

Enacted by Chapter 132, 2015 General Session

Chapter 58
Children with Heart Disease Support Restricted Account

26-58-101 Title.
This chapter is known as the "Children with Heart Disease Support Restricted Account."

Enacted by Chapter 71, 2016 General Session

26-58-102 Children with Heart Disease Support Restricted Account.

(1) As used in this section, "account" means the Children with Heart Disease Support Restricted Account created in Subsection (2).
(2) There is created in the General Fund a restricted account known as the "Children with Heart Disease Support Restricted Account."
(3) The account shall be funded by:
  (a) contributions deposited into the account in accordance with Section 41-1a-422;
  (b) private contributions;
  (c) donations or grants from public or private entities; and
  (d) interest and earnings on fund money.
(4) The Legislature shall appropriate money in the account to the department.
(5) Upon appropriation, the department shall distribute funds in the account to one or more charitable organizations that:
  (a) qualify as being tax exempt under Section 501(c)(3), Internal Revenue Code; and
  (b) have programs that provide awareness, education, support services, and advocacy for and on behalf of children with heart disease.
(6)
  (a) An organization described in Subsection (5) may apply to the department to receive a distribution in accordance with Subsection (5).
  (b) An organization that receives a distribution from the department in accordance with Subsection (5) shall expend the distribution only to provide awareness, education, support services, and advocacy for and on behalf of children with heart disease.
  (c) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules providing procedures for an organization to apply to the department to receive a distribution under Subsection (5).
(7) In accordance with Section 63J-1-602.1, appropriations from the account are nonlapsing.

Enacted by Chapter 71, 2016 General Session

Chapter 59
Telehealth Pilot Program

26-59-101 Title.

This chapter is known as "Telehealth Pilot Program."

Enacted by Chapter 413, 2017 General Session

26-59-102 Definitions.

As used in this section:
(1) "Grant" means a grant awarded by the department under this chapter to a person to develop and implement a project.
(2) "Project" means a telehealth pilot project described in Section 26-59-103.
(3) "Telehealth services" means providing health care remotely through the use of telecommunications technology.

Enacted by Chapter 413, 2017 General Session

26-59-103 Telehealth Pilot Project Grant Program.

(1)

(a) On or before July 1, 2017, the department shall issue a request for proposals, in accordance with Title 63G, Chapter 6a, Utah Procurement Code, to award a grant to one or more persons to develop and implement one or more telehealth pilot projects in the state.

(b) A project described in this section shall run for two years.

(2) The purpose of a project is to:

(a) determine how telehealth services can best be used in the state to:

(i) increase access or convenience to health care, including specialized health care;

(ii) increase timeliness in crisis intervention;

(iii) reduce costs associated with obtaining health care; and

(iv) increase access to health care by rural populations and other underserved populations;

(b) determine the best practices for providing telehealth services in the state; and

(c) identify the types of health care services for which telehealth services may be most beneficial.

(3) A person who applies for a grant under this section shall:

(a) identify the population to which the person will provide telehealth services;

(b) explain how the population described in Subsection (3)(a):

(i) is currently underserved; and

(ii) will benefit from the provision of telehealth services;

(c) provide details regarding:

(i) how the person will provide the telehealth services;

(ii) the projected costs of providing the telehealth services;

(iii) the sustainability of the proposed project; and

(iv) the methods that the person will use to:

(A) protect the privacy of patients;

(B) collect nonidentifying data relating to the project; and

(C) provide transparency on the costs and operation of the project; and

(d) provide other information that the department requests to ensure that the proposed project satisfies the criteria described in Subsection (4).

(4) In evaluating a proposal for a grant, the department shall consider:

(a) the extent to which the proposal will fulfill the purposes described in Subsection (2);

(b) the extent to which the population that will be served by the proposed project:

(i) is currently underserved; and

(ii) is likely to benefit from the proposed project;

(c) the cost of the proposed project;

(d) the viability and innovation of the proposed project; and

(e) the extent to which the proposed project will yield useful data to evaluate the effectiveness of the proposed project.

Enacted by Chapter 413, 2017 General Session

26-59-104 Reporting requirements.

(1) The department shall, before June 30, 2018, report to the Health and Human Services Interim Committee regarding:

(a) each person who received a grant for a project;

(b) the details of the project; and
(c) the duration of the project.
(2) The department shall, before June 30, 2019, report to the Health and Human Services Interim Committee regarding:
(a) the success of each project for which the department awarded a grant;
(b) data gathered in relation to each project;
(c) knowledge gained relating to the provision of telehealth services;
(d) proposals for the future use of telehealth services in the state;
(e) obstacles encountered in the provision of telehealth services; and
(f) changes needed in the law to overcome obstacles to providing telehealth services.

Enacted by Chapter 413, 2017 General Session

Chapter 60
Telehealth Act

26-60-101 Title.
This chapter is known as the "Telehealth Act."

Enacted by Chapter 241, 2017 General Session

26-60-102 Definitions.
As used in this chapter:
(1) "Asynchronous store and forward transfer" means the transmission of a patient's health care information from an originating site to a provider at a distant site.
(2) "Distant site" means the physical location of a provider delivering telemedicine services.
(3) "Originating site" means the physical location of a patient receiving telemedicine services.
(4) "Patient" means an individual seeking telemedicine services.
(5) "Provider" means an individual who is:
(a) licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act;
(b) licensed under Title 58, Occupations and Professions, to provide health care; or
(c) licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.
(6) "Synchronous interaction" means real-time communication through interactive technology that enables a provider at a distant site and a patient at an originating site to interact simultaneously through two-way audio and video transmission.
(7) "Telehealth services" means the transmission of health-related services or information through the use of electronic communication or information technology.
(8) "Telemedicine services" means telehealth services:
(a) including:
(i) clinical care;
(ii) health education;
(iii) health administration;
(iv) home health; or
(v) facilitation of self-managed care and caregiver support; and
(b) provided by a provider to a patient through a method of communication that:
(i)

(A) uses asynchronous store and forward transfer; or
(B) uses synchronous interaction; and
(ii) meets industry security and privacy standards, including compliance with:
(A) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended; and
(B) the federal Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.

Enacted by Chapter 241, 2017 General Session

26-60-103 Scope of telehealth practice.

(1) A provider offering telehealth services shall:
(a) at all times:
(i) act within the scope of the provider's license under Title 58, Occupations and Professions, in accordance with the provisions of this chapter and all other applicable laws and rules; and
(ii) be held to the same standards of practice as those applicable in traditional health care settings;
(b) in accordance with Title 58, Chapter 82, Electronic Prescribing Act, before providing treatment or prescribing a prescription drug, establish a diagnosis and identify underlying conditions and contraindications to a recommended treatment after:
(i) obtaining from the patient or another provider the patient's relevant clinical history; and
(ii) documenting the patient's relevant clinical history and current symptoms;
(c) be available to a patient who receives telehealth services from the provider for subsequent care related to the initial telemedicine services, in accordance with community standards of practice;
(d) be familiar with available medical resources, including emergency resources near the originating site, in order to make appropriate patient referrals when medically indicated; and
(e) in accordance with any applicable state and federal laws, rules, and regulations, generate, maintain, and make available to each patient receiving telehealth services the patient's medical records.
(2) A provider may not offer telehealth services if:
(a) the provider is not in compliance with applicable laws, rules, and regulations regarding the provider's licensed practice; or
(b) the provider's license under Title 58, Occupations and Professions, is not active and in good standing.

Enacted by Chapter 241, 2017 General Session

26-60-104 Enforcement.

(1) The Division of Occupational and Professional Licensing created in Section 58-1-103 is authorized to enforce the provisions of Section 26-60-103 as it relates to providers licensed under Title 58, Occupations and Professions.
(2) The department is authorized to enforce the provisions of Section 26-60-103 as it relates to providers licensed under this title.
(3) The Department of Human Services created in Section 62A-1-102 is authorized to enforce the provisions of Section 26-60-103 as it relates to providers licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

Enacted by Chapter 241, 2017 General Session

26-60-105 Study by Public Utilities, Energy, and Technology Interim Committee and Health Reform Task Force.

The Legislature's Public Utilities, Energy, and Technology Interim Committee and Health Reform Task Force shall receive the reports required in Sections 26-18-13.5 and 49-20-414 and, during the 2019 interim, study:

(1) the result of the reimbursement requirement described in Sections 26-18-13.5 and 49-20-414;
(2) practices and efforts of private health care facilities, health care providers, self-funded employers, third-party payors, and health maintenance organizations to reimburse for telehealth services;
(3) existing and potential uses of telehealth and telemedicine services;
(4) issues of reimbursement to a provider offering telehealth and telemedicine services; and
(5) potential rules or legislation related to:
  (a) providers offering and insurers reimbursing for telehealth and telemedicine services; and
  (b) increasing access to health care, increasing the efficiency of health care, and decreasing the costs of health care.

Amended by Chapter 249, 2019 General Session

Chapter 61
Cannabinoid Research Act

Part 1
General Provisions

26-61-101 Title.

This chapter is known as "Cannabinoid Research Act."

Enacted by Chapter 398, 2017 General Session

26-61-102 Definitions.

As used in this chapter:

(1) "Approved study" means a medical research study:
  (a) the purpose of which is to investigate the medical benefits and risks of cannabinoid products; and
  (b) that is approved by an IRB.
(2) "Board" means the Cannabinoid Product Board created in Section 26-61-201.
(3) "Cannabinoid product" means the same as that term is defined in Section 58-37-3.6.
(4) "Cannabis" means the same as that term is defined in Section 58-37-3.6.
(5) "Expanded cannabinoid product" means the same as that term is defined in Section 58-37-3.6.
(6) "Institutional review board" or "IRB" means an institutional review board that is registered for human subject research by the United States Department of Health and Human Services.

Enacted by Chapter 398, 2017 General Session

26-61-103 Institutional review board -- Approved study of cannabis, a cannabinoid product, or an expanded cannabinoid product.

(1) A person conducting an approved study may, for the purposes of the study:
  (a) process a cannabinoid product or an expanded cannabinoid product;
  (b) possess a cannabinoid product or an expanded cannabinoid product; and
  (c) administer a cannabinoid product, or an expanded cannabinoid product to an individual in accordance with the approved study.
(2) A person conducting an approved study may:
  (a) import cannabis, a cannabinoid product, or an expanded cannabinoid product from another state if:
    (i) the importation complies with federal law; and
    (ii) the person uses the cannabis, cannabinoid product, or expanded cannabinoid product in accordance with the approved study; or
  (b) obtain cannabis, a cannabinoid product, or an expanded cannabinoid product from the National Institute on Drug Abuse.
(3) A person conducting an approved study may distribute cannabis, a cannabinoid product, or an expanded cannabinoid product outside the state if:
  (a) the distribution complies with federal law; and
  (b) the distribution is for the purposes of, and in accordance with, the approved study.

Enacted by Chapter 398, 2017 General Session

Part 2
Cannabinoid Product Board

26-61-201 Cannabinoid Product Board.

(1) There is created the Cannabinoid Product Board within the department.
(2) The department shall appoint, in consultation with a professional association based in the state that represents physicians, seven members to the Cannabinoid Product Board as follows:
  (a) three individuals who are medical research professionals; and
  (b) four physicians.
(3) The department shall ensure that at least one of the board members appointed under Subsection (2) is a member of the Controlled Substances Advisory Committee created in Section 58-38a-201.
(4)
  (a) Four of the board members appointed under Subsection (2) shall serve an initial term of two years and three of the board members appointed under Subsection (2) shall serve an initial term of four years.
  (b) Successor board members shall each serve a term of four years.
(5) The department may remove a board member without cause.
(6) The board shall nominate a board member to serve as chairperson of the board by a majority vote of the board members.
(7) The board shall meet as often as necessary to accomplish the duties assigned to the board under this chapter.
(8) Each board member, including the chair, has one vote.
(9)

(a) A majority of board members constitutes a quorum.
(b) A vote of a majority of the quorum at any board meeting is necessary to take action on behalf of the board.
(10) A board member may not receive compensation for the member's service on the board, but may, in accordance with rules adopted by the board in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, receive:
(a) per diem at the rate established under Section 63A-3-106; and
(b) travel expenses at the rate established under Section 63A-3-107.

Amended by Chapter 110, 2018 General Session

26-61-202 Cannabinoid Product Board -- Duties.
(1) The board shall review any available scientific research related to the human use of cannabis, a cannabinoid product, or an expanded cannabinoid product that:
(a) was conducted under a study approved by an IRB; or
(b) was conducted or approved by the federal government.
(2) Based on the research described in Subsection (1), the board shall evaluate the safety and efficacy of cannabis, cannabinoid products, and expanded cannabinoid products, including:
(a) medical conditions that respond to cannabis, cannabinoid products, and expanded cannabinoid products;
(b) cannabis and cannabinoid dosage amounts and medical dosage forms;
(c) interaction of cannabis, cannabinoid products, and expanded cannabinoid products with other treatments; and
(d) contraindications, adverse reactions, and potential side effects from use of cannabis, cannabinoid products, and expanded cannabinoid products.
(3) Based on the board's evaluation under Subsection (2), the board shall develop guidelines for treatment with cannabis, a cannabinoid product, and an expanded cannabinoid product that include:
(a) a list of medical conditions, if any, that the board determines are appropriate for treatment with cannabis, a cannabis product, a cannabinoid product, or an expanded cannabinoid product;
(b) a list of contraindications, side effects, and adverse reactions that are associated with use of cannabis, cannabinoid products, or expanded cannabinoid products; and
(c) a list of potential drug-drug interactions between medications that the United States Food and Drug Administration has approved and cannabis, cannabinoid products, and expanded cannabinoid products.
(4) The board shall submit the guidelines described in Subsection (3) to:
(a) the director of the Division of Occupational and Professional Licensing; and
(b) the Health and Human Services Interim Committee.
(5) The board shall report the board's findings before November 1 of each year to the Health and Human Services Interim Committee.
(6) Guidelines that the board develops under this section may not limit the availability of cannabis, cannabinoid products, or expanded cannabinoid products permitted under Title 4, Chapter 41a, Cannabis Production Establishments, or Title 26, Chapter 61a, Utah Medical Cannabis Act.

Amended by Chapter 1, 2018 Special Session 3

Chapter 61a
Utah Medical Cannabis Act

Part 1
General Provisions

26-61a-101 Title.

This chapter is known as "Utah Medical Cannabis Act."

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-102 Definitions.

As used in this chapter:

(1) "Blister" means a plastic cavity or pocket used to contain no more than a single dose of cannabis or a cannabis product in a blister pack.

(2) "Blister pack" means a plastic, paper, or foil package with multiple blisters each containing no more than a single dose of cannabis or a cannabis product.

(3) "Cannabis" means marijuana.

(4) "Cannabis cultivation facility" means the same as that term is defined in Section 4-41a-102.

(5) "Cannabis processing facility" means the same as that term is defined in Section 4-41a-102.

(6) "Cannabis product" means a product that:

(a) is intended for human use; and

(b) contains cannabis or tetrahydrocannabinol.

(7) "Cannabis production establishment agent" means the same as that term is defined in Section 4-41a-102.

(8) "Cannabis production establishment agent registration card" means the same as that term is defined in Section 4-41a-102.

(9) "Community location" means a public or private school, a church, a public library, a public playground, or a public park.

(10) "Department" means the Department of Health.

(11) "Designated caregiver" means an individual:

(a) whom an individual with a medical cannabis patient card or a medical cannabis guardian card designates as the patient's caregiver; and

(b) who registers with the department under Section 26-61a-202.

(12) "Dosing parameters" means quantity, routes, and frequency of administration for a recommended treatment of cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.

(13) "Independent cannabis testing laboratory" means the same as that term is defined in Section 4-41a-102.

(14) "Inventory control system" means the system described in Section 4-41a-103.

(15) "Local health department" means the same as that term is defined in Section 26A-1-102.

(16) "Local health department distribution agent" means an agent designated and registered to distribute state central fill shipments under Sections 26-61a-606 and 26-61a-607.

(17) "Marijuana" means the same as that term is defined in Section 58-37-2.

(18) "Medical cannabis" means cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.

(19) "Medical cannabis card" means a medical cannabis patient card, a medical cannabis guardian card, or a medical cannabis caregiver card.
(20) "Medical cannabis cardholder" means a holder of a medical cannabis card.
(21) "Medical cannabis caregiver card" means an official card that:
(a) the department issues to an individual whom a medical cannabis patient cardholder or a medical cannabis guardian cardholder designates as a designated caregiver; and
(b) is connected to the electronic verification system.
(22)
(a) "Medical cannabis device" means a device that an individual uses to ingest cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.
(b) "Medical cannabis device" does not include a device that:
(i) facilitates cannabis combustion; or
(ii) an individual uses to ingest substances other than cannabis.
(23) "Medical cannabis guardian card" means an official card that:
(a) the department issues to the parent or legal guardian of a minor with a qualifying condition; and
(b) is connected to the electronic verification system.
(24) "Medical cannabis patient card" means an official card that:
(a) the department issues to an individual with a qualifying condition; and
(b) is connected to the electronic verification system.
(25) "Medical cannabis pharmacy" means a person that:
(a)
(i) acquires or intends to acquire:
(A) cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form from a cannabis processing facility; or
(B) a medical cannabis device; or
(ii) possesses cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device; and
(b) sells or intends to sell cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device to a medical cannabis cardholder.
(26) "Medical cannabis pharmacy agent" means an individual who:
(a) is an employee of a medical cannabis pharmacy; and
(b) who holds a valid medical cannabis pharmacy agent registration card.
(27) "Medical cannabis pharmacy agent registration card" means a registration card issued by the department that authorizes an individual to act as a medical cannabis pharmacy agent.
(28) "Medical cannabis treatment" means cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device.
(29)
(a) "Medicinal dosage form" means:
(i) for processed medical cannabis or a medical cannabis product, the following with a specific and consistent cannabinoid content:
(A) a tablet;
(B) a capsule;
(C) a concentrated oil;
(D) a liquid suspension;
(E) a topical preparation;
(F) a transdermal preparation;
(G) a sublingual preparation;

(H) a gelatinous cube, gelatinous rectangular cuboid, or lozenge in a cube or rectangular cuboid shape; or

(I) for use only after the individual's qualifying condition has failed to substantially respond to at least two other forms described in this Subsection (29)(a)(i), a resin or wax;

(ii) for unprocessed cannabis flower, a blister pack, with each individual blister:

(A) containing a specific and consistent weight that does not exceed one gram and that varies by no more than 10% from the stated weight; and

(B) after December 31, 2020, labeled with a barcode that provides information connected to an inventory control system and the individual blister's content and weight; and

(iii) a form measured in grams, milligrams, or milliliters.

(b) "Medicinal dosage form" includes a portion of unprocessed cannabis flower that:

(i) the medical cannabis cardholder has recently removed from the blister pack described in Subsection (29)(a)(ii) for use; and

(ii) does not exceed the quantity described in Subsection (29)(a)(ii).

(c) "Medicinal dosage form" does not include:

(i) any unprocessed cannabis flower outside of the blister pack, except as provided in Subsection (29)(b); or

(ii) a process of vaporizing and inhaling concentrated cannabis by placing the cannabis on a nail or other metal object that is heated by a flame, including a blowtorch.

(30) "Pharmacy medical provider" means the medical provider required to be on site at a medical cannabis pharmacy under Section 26-61a-403.

(31) "Provisional patient card" means a card that:

(a) the department issues to a minor with a qualifying condition for whom:

(i) a qualified medical provider has recommended a medical cannabis treatment; and

(ii) the department issues a medical cannabis guardian card to the minor's parent or legal guardian; and

(b) is connected to the electronic verification system.

(32) "Qualified medical provider" means an individual who is qualified to recommend treatment with cannabis in a medicinal dosage form under Section 26-61a-106.

(33) "Qualified Distribution Enterprise Fund" means the enterprise fund created in Section 26-61a-110.

(34) "Qualified Patient Enterprise Fund" means the enterprise fund created in Section 26-61a-109.

(35) "Qualifying condition" means a condition described in Section 26-61a-104.

(36) "State central fill agent" means an employee of the state central fill medical cannabis pharmacy that the department registers in accordance with Section 26-61a-602.

(37) "State central fill medical cannabis pharmacy" means the central fill pharmacy that the department creates in accordance with Section 26-61a-601.

(38) "State central fill medical provider" means a physician or pharmacist that the state central fill medical cannabis pharmacy employs to consult with medical cannabis cardholders in accordance with Section 26-61a-601.

(39) "State central fill shipment" means a shipment of cannabis in a medicinal dosage form, cannabis product in a medicinal dosage form, or a medical cannabis device that the state central fill medical cannabis pharmacy prepares and ships for distribution to a medical cannabis cardholder in a local health department.

(40) "State electronic verification system" means the system described in Section 26-61a-103.

Amended by Chapter 341, 2019 General Session

26-61a-103 Electronic verification system.

(1) The Department of Agriculture and Food, the department, the Department of Public Safety, and the Department of Technology Services shall:

(a) enter into a memorandum of understanding in order to determine the function and operation of the state electronic verification system in accordance with Subsection (2);

(b) coordinate with the Division of Purchasing, under Title 63G, Chapter 6a, Utah Procurement Code, to develop a request for proposals for a third-party provider to develop and maintain the state electronic verification system in coordination with the Department of Technology Services; and

(c) select a third-party provider who:

(i) meets the requirements contained in the request for proposals issued under Subsection (1)(b); and

(ii) may not have any commercial or ownership interest in a cannabis production establishment or a medical cannabis pharmacy.

(2) The Department of Agriculture and Food, the department, the Department of Public Safety, and the Department of Technology Services shall ensure that, on or before March 1, 2020, the state electronic verification system described in Subsection (1):

(a) allows an individual, with the individual's qualified medical provider in the qualified medical provider's office, to apply for a medical cannabis patient card or, if applicable, a medical cannabis guardian card;

(b) allows an individual to apply to renew a medical cannabis patient card or a medical cannabis guardian card in accordance with Section 26-61a-201;

(c) allows a qualified medical provider to:

(i) access dispensing and card status information regarding a patient:

(A) with whom the qualified medical provider has a provider-patient relationship; and

(B) for whom the qualified medical provider has recommended or is considering recommending a medical cannabis card;

(ii) electronically recommend, during a visit with a patient, treatment with cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form and optionally recommend dosing parameters;

(iii) electronically renew a recommendation to a medical cannabis patient cardholder or medical cannabis guardian cardholder:

(A) for the qualified medical provider who originally recommended a medical cannabis treatment, as that term is defined in Section 26-61a-102, using telehealth services; or

(B) for a qualified medical provider who did not originally recommend the medical cannabis treatment, during a face-to-face visit with a patient; and

(iv) at the request of a medical cannabis cardholder, initiate a state central fill shipment in accordance with Section 26-61a-603;

(d) connects with:

(i) an inventory control system that a medical cannabis pharmacy and the state central fill medical cannabis pharmacy use to track in real time and archive purchases of any cannabis in a medicinal dosage form, cannabis product in a medicinal dosage form, or a medical cannabis device, including:

(A) the time and date of each purchase;

(B) the quantity and type of cannabis, cannabis product, or medical cannabis device purchased;

(C) any cannabis production establishment, any medical cannabis pharmacy, or the state central fill medical cannabis pharmacy associated with the cannabis, cannabis product, or medical cannabis device; and

(D) the personally identifiable information of the medical cannabis cardholder who made the purchase; and

(ii) any commercially available inventory control system that a cannabis production establishment utilizes in accordance with Section 4-41a-103 to use data that the Department of Agriculture and Food requires by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, from the inventory tracking system that a licensee uses to track and confirm compliance;

(e) provides access to:

(i) the department to the extent necessary to carry out the department's functions and responsibilities under this chapter;

(ii) the Department of Agriculture and Food to the extent necessary to carry out the functions and responsibilities of the Department of Agriculture and Food under Title 4, Chapter 41a, Cannabis Production Establishments; and

(iii) the Division of Occupational and Professional Licensing to the extent necessary to carry out the functions and responsibilities related to the participation of the following in the recommendation and dispensing of medical cannabis:

(A) a pharmacist licensed under Title 58, Chapter 17b, Pharmacy Practice Act;

(B) an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act;

(C) a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; or

(D) a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant Act;

(f) provides access to and interaction with the state central fill medical cannabis pharmacy, state central fill agents, and local health department distribution agents, to facilitate the state central fill shipment process;

(g) provides access to state or local law enforcement:

(i) during a traffic stop for the purpose of determining if the individual subject to the traffic stop is in compliance with state medical cannabis law; or

(ii) after obtaining a warrant; and

(h) creates a record each time a person accesses the database that identifies the person who accesses the database and the individual whose records the person accesses.

(3) The department may release de-identified data that the system collects for the purpose of:

(a) conducting medical research; and

(b) providing the report required by Section 26-61a-703.

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

(a) the limitations on access to the data in the state electronic verification system as described in this section; and

(b) standards and procedures to ensure accurate identification of an individual requesting information or receiving information in this section.

(5)

(a) Any person who knowingly and intentionally releases any information in the state electronic verification system in violation of this section is guilty of a third degree felony.

(b) Any person who negligently or recklessly releases any information in the state electronic verification system in violation of this section is guilty of a class C misdemeanor.

(6)
(a) Any person who obtains or attempts to obtain information from the state electronic verification system by misrepresentation or fraud is guilty of a third degree felony.
(b) Any person who obtains or attempts to obtain information from the state electronic verification system for a purpose other than a purpose this chapter authorizes is guilty of a third degree felony.
(7)
(a) Except as provided in Subsection (7)(e), a person may not knowingly and intentionally use, release, publish, or otherwise make available to any other person information obtained from the state electronic verification system for any purpose other than a purpose specified in this section.
(b) Each separate violation of this Subsection (7) is:
(i) a third degree felony; and
(ii) subject to a civil penalty not to exceed $5,000.
(c) The department shall determine a civil violation of this Subsection (7) in accordance with Title 63G, Chapter 4, Administrative Procedures Act.
(d) Civil penalties assessed under this Subsection (7) shall be deposited into the General Fund.
(e) This Subsection (7) does not prohibit a person who obtains information from the state electronic verification system under Subsection (2)(a), (c), or (f) from:
(i) including the information in the person's medical chart or file for access by a person authorized to review the medical chart or file;
(ii) providing the information to a person in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996; or
(iii) discussing or sharing that information about the patient with the patient.

Amended by Chapter 136, 2019 General Session
Amended by Chapter 341, 2019 General Session

26-61a-104 Qualifying condition.
(1) By designating a particular condition under Subsection (2) for which the use of medical cannabis to treat symptoms is decriminalized, the Legislature does not conclusively state that:
(a) current scientific evidence clearly supports the efficacy of a medical cannabis treatment for the condition; or
(b) a medical cannabis treatment will treat, cure, or positively affect the condition.
(2) For the purposes of this chapter, each of the following conditions is a qualifying condition:
(a) HIV or acquired immune deficiency syndrome;
(b) Alzheimer's disease;
(c) amyotrophic lateral sclerosis;
(d) cancer;
(e) cachexia;
(f) persistent nausea that is not significantly responsive to traditional treatment, except for nausea related to:
(i) pregnancy;
(ii) cannabis-induced cyclical vomiting syndrome; or
(iii) cannabinoid hyperemesis syndrome;
(g) Crohn's disease or ulcerative colitis;
(h) epilepsy or debilitating seizures;
(i) multiple sclerosis or persistent and debilitating muscle spasms;

(j) post-traumatic stress disorder that is being treated and monitored by a licensed mental health therapist, as that term is defined in Section 58-60-102, and that:
(i) has been diagnosed by a healthcare provider or mental health provider employed or contracted by the United States Veterans Administration, evidenced by copies of medical records from the United States Veterans Administration that are included as part of the qualified medical provider's pre-treatment assessment and medical record documentation; or
(ii) has been diagnosed or confirmed, through face-to-face or telehealth evaluation of the patient, by a provider who is:
(A) a licensed board-eligible or board-certified psychiatrist;
(B) a licensed psychologist with a doctorate-level degree;
(C) a licensed clinical social worker with a doctorate-level degree; or
(D) a licensed advanced practice registered nurse who is qualified to practice within the psychiatric mental health nursing speciality and who has completed the clinical practice requirements in psychiatric mental health nursing, including in psychotherapy, in accordance with Subsection 58-31b-302(4)(g);
(k) autism;
(l) a terminal illness when the patient's remaining life expectancy is less than six months;
(m) a condition resulting in the individual receiving hospice care;
(n) a rare condition or disease that:
(i) affects less than 200,000 individuals in the United States, as defined in Section 526 of the Federal Food, Drug, and Cosmetic Act; and
(ii) is not adequately managed despite treatment attempts using:
(A) conventional medications other than opioids or opiates; or
(B) physical interventions;
(o) pain lasting longer than two weeks that is not adequately managed, in the qualified medical provider's opinion, despite treatment attempts using:
(i) conventional medications other than opioids or opiates; or
(ii) physical interventions; and
(p) a condition that the compassionate use board approves under Section 26-61a-105, on an individual, case-by-case basis.

Amended by Chapter 136, 2019 General Session

26-61a-105 Compassionate use board.
(1)
(a) The department shall establish a compassionate use board consisting of:
(i) seven qualified medical providers that the executive director appoints and the Senate confirms:
(A) who are knowledgeable about the medicinal use of cannabis;
(B) who are physicians licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; and
(C) whom the appropriate board certifies in the specialty of neurology, pain medicine and pain management, medical oncology, psychiatry, infectious disease, internal medicine, pediatrics, or gastroenterology; and
(ii) as a nonvoting member and the chair of the board, the executive director or the director's designee.

(b) In appointing the seven qualified medical providers described in Subsection (1)(a), the executive director shall ensure that at least two have a board certification in pediatrics.

(2)

(a) Of the members of the board that the executive director first appoints:

(i) three shall serve an initial term of two years; and

(ii) the remaining members shall serve an initial term of four years.

(b) After an initial term described in Subsection (2)(a) expires:

(i) each term is four years; and

(ii) each board member is eligible for reappointment.

(c) A member of the board may serve until a successor is appointed.

(3) Four members constitute a quorum of the compassionate use board.

(4) A member of the board may receive:

(a) compensation or benefits for the member's service; and

(b) per diem and travel expenses in accordance with Section 63A-3-106, Section 63A-3-107, and rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

(5) The compassionate use board shall:

(a) review and recommend for department approval an individual described in Subsection 26-61a-201(2)(a), a minor described in Subsection 26-61a-201(2)(c), or an individual who is not otherwise qualified to receive a medical cannabis card to obtain a medical cannabis card for compassionate use if:

(i) for an individual who is not otherwise qualified to receive a medical cannabis card, the individual's qualified medical provider is actively treating the individual for an intractable condition that:

(A) substantially impairs the individual's quality of life; and

(B) has not, in the qualified medical provider's professional opinion, adequately responded to conventional treatments;

(ii) the qualified medical provider:

(A) recommends that the individual or minor be allowed to use medical cannabis; and

(B) provides a letter, relevant treatment history, and notes or copies of progress notes describing relevant treatment history including rationale for considering the use of medical cannabis; and

(iii) the board determines that:

(A) the recommendation of the individual's qualified medical provider is justified; and

(B) based on available information, it may be in the best interests of the individual to allow the use of medical cannabis;

(b) unless no petitions are pending:

(i) meet to receive or review compassionate use petitions at least quarterly; and

(ii) if there are more petitions than the board can receive or review during the board's regular schedule, as often as necessary;

(c) complete a review of each petition and recommend to the department approval or denial of the applicant for qualification for a medical cannabis card within 90 days after the day on which the board received the petition; and

(d) report, before November 1 of each year, to the Health and Human Services Interim Committee:

(i) the number of compassionate use recommendations the board issued during the past year; and

(ii) the types of conditions for which the board approved compassionate use.

(6)

(a)
(i) The department shall review any compassionate use for which the board recommends approval under Subsection (5)(c) to determine whether the board properly exercised the board's discretion under this section.
(ii) If the department determines that the board properly exercised the board's discretion in recommending approval under Subsection (5)(c), the department shall:
(A) issue the relevant medical cannabis card; and
(B) provide for the renewal of the medical cannabis card in accordance with the recommendation of the qualified medical provider described in Subsection (5)(a).
(b)
(i) If the board recommends denial under Subsection (5)(c), the individual seeking to obtain a medical cannabis card may petition the department to review the board's decision.
(ii) If the department determines that the board's recommendation for denial under Subsection (5)(c) was arbitrary or capricious:
(A) the department shall notify the board of the department's determination; and
(B) the board shall reconsider the board's refusal to recommend approval under this section.
(c) In reviewing the board's recommendation for approval or denial under Subsection (5)(c) in accordance with this Subsection (6), the department shall presume the board properly exercised the board's discretion unless the department determines that the board's recommendation was arbitrary or capricious.
(7) Any individually identifiable health information contained in a petition that the board or department receives under this section is a protected record in accordance with Title 63G, Chapter 2, Government Records Access and Management Act.
(8) The compassionate use board shall annually report the board's activity to the Cannabinoid Product Board created in Section 26-61-201.

Amended by Chapter 341, 2019 General Session

26-61a-106 Qualified medical provider registration -- Continuing education -- Treatment recommendation.
(1)
(a) Except as provided in Subsection (1)(b), an individual may not recommend a medical cannabis treatment unless the department registers the individual as a qualified medical provider in accordance with this section.
(b) An individual who meets the qualifications in Subsections 26-61a-106(2)(a)(iii) and (iv) may recommend a medical cannabis treatment without registering under Subsection (1)(a) until January 1, 2021.
(2)
(a) The department shall, within 15 days after the day on which the department receives an application from an individual, register and issue a qualified medical provider registration card to the individual if the individual:
(i) provides to the department the individual's name and address;
(ii) provides to the department a report detailing the individual's completion of the applicable continuing education requirement described in Subsection (3);
(iii) provides to the department evidence that the individual:
(A) has the authority to write a prescription;
(B) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah Controlled Substances Act; and

(C) possesses the authority, in accordance with the individual's scope of practice, to prescribe a Schedule II controlled substance;

(iv) provides to the department evidence that the individual is:

(A) an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act;

(B) a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; or

(C) a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant Act, whose declaration of services agreement, as that term is defined in Section 58-70a-102, includes the recommending of medical cannabis, and whose supervising physician is a qualified medical provider; and

(v) pays the department a fee in an amount that:

(A) the department sets, in accordance with Section 63J-1-504; and

(B) does not exceed $300 for an initial registration.

(b) The department may not register an individual as a qualified medical provider if the individual is:

(i) a pharmacy medical provider or a state central fill medical provider; or

(ii) an owner, officer, director, board member, employee, or agent of a cannabis production establishment or a medical cannabis pharmacy.

(3)

(a) An individual shall complete the continuing education described in this Subsection (3) in the following amounts:

(i) for an individual as a condition precedent to registration, four hours; and

(ii) for a qualified medical provider as a condition precedent to renewal, four hours every two years.

(b) In accordance with Subsection (3)(a), a qualified medical provider shall:

(i) complete continuing education:

(A) regarding the topics described in Subsection (3)(d); and

(B) offered by the department under Subsection (3)(c) or an accredited or approved continuing education provider that the department recognizes as offering continuing education appropriate for the recommendation of cannabis to patients; and

(ii) make a continuing education report to the department in accordance with a process that the department establishes by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in collaboration with the Division of Occupational and Professional Licensing and:

(A) for an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act, the Board of Nursing;

(B) for a qualified medical provider licensed under Title 58, Chapter 67, Utah Medical Practice Act, the Physicians Licensing Board;

(C) for a qualified medical provider licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, the Osteopathic Physician and Surgeon's Licensing Board; and

(D) for a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant Act, the Physician Assistant Licensing Board.

(c) The department may, in consultation with the Division of Occupational and Professional Licensing, develop the continuing education described in this Subsection (3).

(d) The continuing education described in this Subsection (3) may discuss:

(i) the provisions of this chapter;

(ii) general information about medical cannabis under federal and state law;

(iii) the latest scientific research on the endocannabinoid system and medical cannabis, including risks and benefits;

(iv) recommendations for medical cannabis as it relates to the continuing care of a patient in pain management, risk management, potential addiction, or palliative care; and

(v) best practices for recommending the form and dosage of medical cannabis products based on the qualifying condition underlying a medical cannabis recommendation.

(4)

(a) Except as provided in Subsection (4)(b) or (c), a qualified medical provider may not recommend a medical cannabis treatment to more than 175 of the qualified medical provider's patients at the same time, as determined by the number of medical cannabis cards under the qualified medical provider's name in the state electronic verification system.

(b) Except as provided in Subsection (4)(c), a qualified medical provider may recommend a medical cannabis treatment to up to 300 of the qualified medical provider's patients at any given time, as determined by the number of medical cannabis cards under the qualified medical provider's name in the state electronic verification system, if:

(i) the appropriate American medical board has certified the qualified medical provider in the specialty of anesthesiology, gastroenterology, neurology, oncology, pain, hospice and palliative medicine, physical medicine and rehabilitation, rheumatology, or psychiatry; or

(ii) a licensed business employs or contracts with the qualified medical provider for the specific purpose of providing hospice and palliative care.

(c)

(i) Notwithstanding Subsection (4)(b), a qualified medical provider described in Subsection (4)(b) may petition the Division of Occupational and Professional Licensing for authorization to exceed the limit described in Subsection (4)(b) by graduating increments of 100 patients per authorization, not to exceed three authorizations.

(ii) The Division of Occupational and Professional Licensing shall grant the authorization described in Subsection (4)(c)(i) if:

(A) the petitioning qualified medical provider pays a $100 fee;

(B) the division performs a review that includes the qualified medical provider's medical cannabis recommendation activity in the state electronic verification system, relevant information related to patient demand, and any patient medical records that the division determines would assist in the division's review; and

(C) after the review described in this Subsection (4)(c)(ii), the division determines that granting the authorization would not adversely affect public safety, adversely concentrate the overall patient population among too few qualified medical providers, or adversely concentrate the use of medical cannabis among the provider's patients.

(5) A qualified medical provider may recommend medical cannabis to an individual under this chapter only in the course of a qualified medical provider-patient relationship after the qualifying medical provider has completed and documented in the patient's medical record a thorough assessment of the patient's condition and medical history based on the appropriate standard of care for the patient's condition.

(6)

(a) Except as provided in Subsection (6)(b), a qualified medical provider may not advertise that the qualified medical provider recommends medical cannabis treatment.

(b) For purposes of Subsection (6)(a), the communication of the following, through a website does not constitute advertising:

(i) a green cross;

(ii) a qualifying condition that the qualified medical provider treats; or

(iii) a scientific study regarding medical cannabis use.

(7)

(a) A qualified medical provider registration card expires two years after the day on which the department issues the card.

(b) The department shall renew a qualified medical provider's registration card if the provider:

(i) applies for renewal;

(ii) is eligible for a qualified medical provider registration card under this section, including maintaining an unrestricted license as described in Subsection (2)(a)(iii);

(iii) certifies to the department in a renewal application that the information in Subsection (2)(a) is accurate or updates the information;

(iv) submits a report detailing the completion of the continuing education requirement described in Subsection (3); and

(v) pays the department a fee in an amount that:

(A) the department sets, in accordance with Section 63J-1-504; and

(B) does not exceed $50 for a registration renewal.

(8) The department may revoke the registration of a qualified medical provider who fails to maintain compliance with the requirements of this section.

(9) A qualified medical provider may not receive any compensation or benefit for the qualified medical provider's medical cannabis treatment recommendation from:

(a) a cannabis production establishment or an owner, officer, director, board member, employee, or agent of a cannabis production establishment;

(b) a medical cannabis pharmacy or an owner, officer, director, board member, employee, or agent of a medical cannabis pharmacy; or

(c) a qualified medical provider or pharmacy medical provider.

Amended by Chapter 136, 2019 General Session
Amended by Chapter 341, 2019 General Session

26-61a-107 Standard of care -- Physicians and pharmacists not liable -- No private right of action.

(1) An individual described in Subsection (2) is not subject to the following solely for violating a federal law or regulation that would otherwise prohibit recommending, prescribing, or dispensing medical cannabis, a medical cannabis product, or a cannabis-based drug that the United States Food and Drug Administration has not approved:

(a) civil or criminal liability; or

(b) licensure sanctions under Title 58, Chapter 17b, Pharmacy Practice Act, Title 58, Chapter 31b, Nurse Practice Act, Title 58, Chapter 67, Utah Medical Practice Act, Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, or Title 58, Chapter 70a, Utah Physician Assistant Act.

(2) The limitations of liability described in Subsection (1) apply to:

(a) an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act, a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, or a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant Act:

(i)

(A) whom the department has registered as a qualified medical provider; and

(B) who recommends treatment with cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form to a patient in accordance with this chapter; or

(ii) before January 1, 2021, who:
(A) has the authority to write a prescription; and
(B) recommends a medical cannabis treatment to a patient who has a qualifying condition; and
(b) a pharmacist licensed under Title 58, Chapter 17b, Pharmacy Practice Act:
(i) whom the department has registered as a pharmacy medical provider or a state central fill medical provider; and
(ii) who dispenses, in a medical cannabis pharmacy or the state central fill medical cannabis pharmacy, treatment with cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form to a medical cannabis cardholder in accordance with this chapter.
(3) Nothing in this section or chapter reduces or in any way negates the duty of an individual described in Subsection (2) to use reasonable and ordinary care in the treatment of a patient:
(a) who may have a qualifying condition; and
(b)
(i) for whom the individual described in Subsection (2)(a)(i) or (ii) has recommended or might consider recommending a treatment with cannabis or a cannabis product; or
(ii) with whom the pharmacist described in Subsection (2)(b) has interacted in the dosing or dispensing of cannabis or a cannabis product.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-108 Agreement with a tribe.
(1) As used in this section, "tribe" means a federally recognized Indian tribe or Indian band.
(2)
(a) In accordance with this section, the governor may enter into an agreement with a tribe to allow for the operation of a medical cannabis pharmacy on tribal land located within the state.
(b) An agreement described in Subsection (2)(a) may not exempt any person from the requirements of this chapter.
(c) The governor shall ensure that an agreement described in Subsection (2)(a):
(i) is in writing;
(ii) is signed by:
(A) the governor; and
(B) the governing body of the tribe that the tribe designates and has the authority to bind the tribe to the terms of the agreement;
(iii) states the effective date of the agreement;
(iv) provides that the governor shall renegotiate the agreement if the agreement is or becomes inconsistent with a state statute; and
(v) includes any accommodation that the tribe makes:
(A) to which the tribe agrees; and
(B) that is reasonably related to the agreement.
(d) Before executing an agreement under this Subsection (2), the governor shall consult with the department.
(e) At least 30 days before the execution of an agreement described in this Subsection (2), the governor or the governor's designee shall provide a copy of the agreement in the form in which the agreement will be executed to:
(i) the chairs of the Native American Legislative Liaison Committee; and
(ii) the Office of Legislative Research and General Counsel.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-109 Qualified Patient Enterprise Fund -- Creation -- Revenue neutrality.

(1) There is created an enterprise fund known as the "Qualified Patient Enterprise Fund."
(2) The fund created in this section is funded from:
  (a) money the department deposits into the fund under this chapter;
  (b) appropriations the Legislature makes to the fund; and
  (c) the interest described in Subsection (3).
(3) Interest earned on the fund shall be deposited into the fund.
(4) The department may only use money in the fund to fund the department's responsibilities under this chapter, except for the responsibilities described in Subsection 26-61a-110(4).
(5) The department shall set fees authorized under this chapter in amounts that the department anticipates are necessary, in total, to cover the department's cost to implement this chapter.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-110 Qualified Distribution Enterprise Fund -- Creation.

(1) There is created an enterprise fund known as the "Qualified Distribution Enterprise Fund."
(2) The fund created in this section is funded from:
  (a) money the department deposits into the fund from the operation of the state central fill medical cannabis pharmacy under this chapter;
  (b) appropriations the Legislature makes to the fund; and
  (c) the interest described in Subsection (3).
(3) Interest earned on the fund shall be deposited into the fund.
(4) The department may only use money in the fund to fund the operation of the state central fill medical cannabis pharmacy.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-111 Nondiscrimination for medical care or government employment -- Notice to prospective and current public employees.

(1) For purposes of medical care, including an organ or tissue transplant, a patient's use, in accordance with this chapter, of cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form:
  (a) is considered the equivalent of the authorized use of any other medication used at the discretion of a physician; and
  (b) does not constitute the use of an illicit substance or otherwise disqualify an individual from needed medical care.
(2)
  (a) Notwithstanding any other provision of law and except as provided in Subsection (2)(b), the state or any political subdivision shall treat an employee's use of medical cannabis in accordance with this chapter or Section 58-37-3.7 in the same way the state or political subdivision treats employee use of opioids and opiates.
  (b) Subsection (2)(a) does not apply where the application of Subsection (2)(a) would jeopardize federal funding, a federal security clearance, or any other federal background determination required for the employee's position.
(3)
  (a)

(i) A state employer or a political subdivision employer shall take the action described in Subsection (3)(a)(ii) before:
(A) giving to a current employee an assignment or duty that arises from or directly relates to an obligation under this chapter; or
(B) hiring a prospective employee whose assignments or duties would include an assignment or duty that arises from or directly relates to an obligation under this chapter.
(ii) The employer described in Subsection (3)(a)(i) shall give the employee or prospective employee described in Subsection (3)(a)(i) a written notice that notifies the employee or prospective employee:
(A) that the employee's or prospective employee's job duties may require the employee or prospective employee to engage in conduct which is in violation of the criminal laws of the United States; and
(B) that in accepting a job or undertaking a duty described in Subsection (3)(a)(i), although the employee or prospective employee is entitled to the protections of Title 67, Chapter 21, Utah Protection of Public Employees Act, the employee may not object or refuse to carry out an assignment or duty that may be a violation of the criminal laws of the United States with respect to the manufacture, sale, or distribution of cannabis.
(b) The Department of Human Resource Management shall create, revise, and publish the form of the notice described in Subsection (3)(a).
(c) Notwithstanding Subsection 67-21-3(3), an employee who has signed the notice described in Subsection (3)(a) may not:
(i) claim in good faith that the employee's actions violate or potentially violate the laws of the United States with respect to the manufacture, sale, or distribution of cannabis; or
(ii) refuse to carry out a directive that the employee reasonably believes violates the criminal laws of the United States with respect to the manufacture, sale, or distribution of cannabis.
(d) An employer of an employee who has signed the notice described in Subsection (3)(a) may not take retaliatory action as defined in Section 67-19a-101 against a current employee who refuses to sign the notice described in Subsection (3)(a).

Amended by Chapter 341, 2019 General Session

26-61a-112 No insurance requirement.

Nothing in this chapter requires an insurer, a third-party administrator, or an employer to pay or reimburse for cannabis, a cannabis product, or a medical cannabis device.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-113 No effect on use of hemp extract -- Cannabidiol -- Approved drugs.

(1) Nothing in this chapter prohibits an individual:
(a) with a valid hemp extract registration card that the department issues under Section 26-56-103 from possessing, administering, or using hemp extract in accordance with Section 58-37-4.3; or
(b) from purchasing, selling, possessing, or using a cannabidiol product in accordance with Section 4-41-402.
(2) Nothing in this chapter restricts or otherwise affects the prescription, distribution, or dispensing of a product that the United States Food and Drug Administration has approved.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-114 Severability clause.

(1) If any provision of this title or this bill or the application of any provision of this title or this bill to any person or circumstance is held invalid by a final decision of a court of competent jurisdiction, the remaining provisions of this title and this bill remain effective without the invalidated provision or application.

(2) The provisions of this title and this bill are severable.

Enacted by Chapter 1, 2018 Special Session 3

Part 2
Medical Cannabis Card Registration

26-61a-201 Medical cannabis patient card -- Medical cannabis guardian card application -- Fees -- Studies.

(1) On or before March 1, 2020, the department shall, within 15 days after the day on which an individual who satisfies the eligibility criteria in this section or Section 26-61a-202 submits an application in accordance with this section or Section 26-61a-202:

(a) issue a medical cannabis patient card to an individual described in Subsection (2)(a);

(b) issue a medical cannabis guardian card to an individual described in Subsection (2)(b);

(c) issue a provisional patient card to a minor described in Subsection (2)(c); and

(d) issue a medical cannabis caregiver card to an individual described in Subsection 26-61a-202(4).

(2)

(a) An individual is eligible for a medical cannabis patient card if:

(i)

(A) the individual is at least 21 years old; or

(B) the individual is 18, 19, or 20 years old, the individual petitions the compassionate use board under Section 26-61a-105, and the compassionate use board recommends department approval of the petition;

(ii) the individual is a Utah resident;

(iii) the individual's qualified medical provider recommends treatment with medical cannabis in accordance with Subsection (4);

(iv) the individual signs an acknowledgment stating that the individual received the information described in Subsection (8); and

(v) the individual pays to the department a fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

(b)

(i) An individual is eligible for a medical cannabis guardian card if the individual:

(A) is at least 18 years old;

(B) is a Utah resident;

(C) is the parent or legal guardian of a minor for whom the minor's qualified medical provider recommends a medical cannabis treatment, the individual petitions the compassionate use board under Section 26-61a-105, and the compassionate use board recommends department approval of the petition;

(D) the individual signs an acknowledgment stating that the individual received the information described in Subsection (8);
(E) pays to the department a fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504, plus the cost of the criminal background check described in Section 26-61a-203; and
(F) the individual has not been convicted of a misdemeanor or felony drug distribution offense under either state or federal law, unless the individual completed any imposed sentence six months or more before the day on which the individual applies for a medical cannabis guardian card.
(ii) The department shall notify the Department of Public Safety of each individual that the department registers for a medical cannabis guardian card.
(c)
(i) A minor is eligible for a provisional patient card if:
(A) the minor has a qualifying condition;
(B) the minor's qualified medical provider recommends a medical cannabis treatment to address the minor's qualifying condition;
(C) the minor's parent or legal guardian petitions the compassionate use board under Section 26-61a-105, and the compassionate use board recommends department approval of the petition; and
(D) the minor's parent or legal guardian is eligible for a medical cannabis guardian card under Subsection (2)(b).
(ii) The department shall automatically issue a provisional patient card to the minor described in Subsection (2)(c)(i) at the same time the department issues a medical cannabis guardian card to the minor's parent or legal guardian.
(3)
(a) An individual who is eligible for a medical cannabis card described in Subsection (2)(a) or (b) shall submit an application for a medical cannabis card to the department:
(i) through an electronic application connected to the state electronic verification system;
(ii) with the recommending qualified medical provider while in the recommending qualified medical provider's office; and
(iii) with information including:
(A) the applicant's name, gender, age, and address;
(B) the number of the applicant's valid form of identification that is a valid United States federal- or state-issued photo identification, including a driver license, a United States passport, a United States passport card, or a United States military identification card;
(C) for a medical cannabis guardian card, the name, gender, and age of the minor receiving a medical cannabis treatment under the cardholder's medical cannabis guardian card; and
(D) for a provisional patient card, the name of the minor's parent or legal guardian who holds the associated medical cannabis guardian card.
(b) The department shall ensure that a medical cannabis card the department issues under this section contains the information described in Subsection (3)(a)(iii).
(c)
(i) If a qualified medical provider determines that, because of age, illness, or disability, a medical cannabis patient cardholder requires assistance in administering the medical cannabis treatment that the qualified medical provider recommends, the qualified medical provider may indicate the cardholder's need in the state electronic verification system.
(ii) If a qualified medical provider makes the indication described in Subsection (3)(c)(i):

(A) the department shall add a label to the relevant medical cannabis patient card indicating the cardholder's need for assistance; and
(B) any adult who is 21 years old or older and who is physically present with the cardholder at the time the cardholder needs to use the recommended medical cannabis treatment may handle the medical cannabis treatment and any associated medical cannabis device as needed to assist the cardholder in administering the recommended medical cannabis treatment, including in the event of an emergency medical condition under Subsection 26-61a-204(2).
(iii) A non-cardholding individual acting under Subsection (3)(c)(ii)(B) may not:
(A) ingest or inhale medical cannabis;
(B) possess, transport, or handle medical cannabis or a medical cannabis device outside of the immediate area where the cardholder is present or with an intent other than to provide assistance to the cardholder; or
(C) possess, transport, or handle medical cannabis or a medical cannabis device when the cardholder is not in the process of being dosed with medical cannabis.
(4) To recommend a medical cannabis treatment to a patient or to renew a recommendation, a qualified medical provider shall:
(a) before recommending cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form:
(i) verify the patient's and, for a minor patient, the minor patient's parent or legal guardian's valid form of identification described in Subsection (3)(a);
(ii) review any record related to the patient and, for a minor patient, the patient's parent or legal guardian in:
(A) the state electronic verification system; and
(B) the controlled substance database created in Section 58-37f-201; and
(iii) consider the recommendation in light of the patient's qualifying condition and history of medical cannabis and controlled substance use; and
(b) state in the qualified medical provider's recommendation that the patient:
(i) suffers from a qualifying condition, including the type of qualifying condition; and
(ii) may benefit from treatment with cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.
(5)
(a) Except as provided in Subsection (5)(b), a medical cannabis card that the department issues under this section is valid for the lesser of:
(i) an amount of time that the qualified medical provider determines; or
(ii)
(A) for the first issuance, 30 days; or
(B) for a renewal, six months.
(b)
(i) A medical cannabis card that the department issues in relation to a terminal illness described in Section 26-61a-104 does not expire.
(ii) The recommending qualified medical provider may revoke a recommendation that the provider made in relation to a terminal illness described in Section 26-61a-104 if the medical cannabis cardholder no longer has the terminal illness.
(6)
(a) A medical cannabis patient card or a medical cannabis guardian card is renewable if:
(i) at the time of renewal, the cardholder meets the requirements of Subsection (2)(a) or (b); or

(ii) the cardholder received the medical cannabis card through the recommendation of the compassionate use board under Section 26-61a-105.

(b) A cardholder described in Subsection (6)(a) may renew the cardholder's card:

(i) using the application process described in Subsection (3); or

(ii) through phone or video conference with the qualified medical provider who made the recommendation underlying the card, at the qualifying medical provider's discretion.

(c) A cardholder under Subsection (2)(a) or (b) who renews the cardholder's card shall pay to the department a renewal fee in an amount that:

(i) subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504; and

(ii) may not exceed the cost of the relatively lower administrative burden of renewal in comparison to the original application process.

(d) If a minor meets the requirements of Subsection (2)(c), the minor's provisional patient card renews automatically at the time the minor's parent or legal guardian renews the parent or legal guardian's associated medical cannabis guardian card.

(e) The department may revoke a medical cannabis guardian card if the cardholder under Subsection (2)(b) is convicted of a misdemeanor or felony drug distribution offense under either state or federal law.

(7)

(a) A cardholder under this section shall carry the cardholder's valid medical cannabis card with the patient's name.

(b)

(i) A medical cannabis patient cardholder or a provisional patient cardholder may purchase, in accordance with this chapter and the recommendation underlying the card, cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device.

(ii) A cardholder under this section may possess or transport, in accordance with this chapter and the recommendation underlying the card, cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device.

(iii) To address the qualifying condition underlying the medical cannabis treatment recommendation:

(A) a medical cannabis patient cardholder or a provisional patient cardholder may use cannabis in a medicinal dosage form, a medical cannabis product in a medicinal dosage form, or a medical cannabis device; and

(B) a medical cannabis guardian cardholder may assist the associated provisional patient cardholder with the use of cannabis in a medicinal dosage form, a medical cannabis product in a medicinal dosage form, or a medical cannabis device.

(c) If neither a licensed medical cannabis pharmacy nor the state central fill medical cannabis pharmacy is operating within the state after January 1, 2021, a cardholder under this section is not subject to prosecution for the possession of:

(i) no more than 113 grams of marijuana in a medicinal dosage form;

(ii) an amount of cannabis product in a medicinal dosage form that contains no more than 20 grams of tetrahydrocannabinol; or

(iii) marijuana drug paraphernalia.

(8) The department shall establish by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, a process to provide information regarding the following to an individual receiving a medical cannabis card:

(a) risks associated with medical cannabis treatment;

(b) the fact that a condition's listing as a qualifying condition does not suggest that medical cannabis treatment is an effective treatment or cure for that condition, as described in Subsection 26-61a-104(1); and
(c) other relevant warnings and safety information that the department determines.
(9) The department may establish procedures by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the application and issuance provisions of this section.
(10)
(a) A person may submit, to the department a request to conduct a medical research study using medical cannabis cardholder data that the state electronic verification system contains.
(b) The department shall review a request described in Subsection (10)(a) to determine whether the medical research study is valid.
(c) If the department makes a determination under Subsection (10)(b) that the medical research study is valid, the department shall notify each relevant cardholder asking for the cardholder's consent to participate in the study.
(d) The department may release, for the purposes of a study described in this Subsection (10), information about a cardholder under this section who consents to participate under Subsection (10)(c).
(e) The department may establish standards for a medical research study's validity, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-202 Medical cannabis caregiver card -- Registration -- Renewal -- Revocation.
(1) A cardholder described in Section 26-61a-201 may designate up to two individuals to serve as a designated caregiver for the cardholder if a qualified medical provider determines that, due to physical difficulty or undue hardship, the cardholder needs assistance to obtain the medical cannabis treatment that the qualified medical provider recommends.
(2) An individual that the department registers as a designated caregiver under this section:
(a) may carry a valid medical cannabis caregiver card;
(b) in accordance with this chapter, may purchase, possess, transport, or assist the patient in the use of cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device on behalf of the designating medical cannabis cardholder;
(c) may not charge a fee to an individual to act as the individual's designated caregiver or for a service that the designated caregiver provides in relation to the role as a designated caregiver;
(d) may accept reimbursement from the designating medical cannabis cardholder for direct costs the designated caregiver incurs for assisting with the designating cardholder's medicinal use of cannabis; and
(e) if neither a licensed medical cannabis pharmacy nor the state central fill medical cannabis pharmacy is operating within the state after January 1, 2021, is not subject to prosecution for the possession of:
(i) no more than 113 grams of marijuana in a medicinal dosage form;
(ii) an amount of cannabis product in a medicinal dosage form that contains no more than 20 grams of tetrahydrocannabinol; or
(iii) marijuana drug paraphernalia.
(3)
(a) The department shall:

(i) within 15 days after the day on which an individual submits an application in compliance with this section, issue a medical cannabis card to the applicant if the applicant:
(A) is designated as a caregiver under Subsection (1);
(B) is eligible for a medical cannabis caregiver card under Subsection (4); and
(C) complies with this section; and
(ii) notify the Department of Public Safety of each individual that the department registers as a designated caregiver.
(b) The department shall ensure that a medical cannabis caregiver card contains the information described in Subsection (5)(b).
(4) An individual is eligible for a medical cannabis caregiver card if the individual:
(a) is at least 21 years old;
(b) is a Utah resident;
(c) pays to the department a fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504, plus the cost of the criminal background check described in Section 26-61a-203;
(d) signs an acknowledgment stating that the applicant received the information described in Subsection 26-61a-201(8); and
(e) has not been convicted of a misdemeanor or felony drug distribution offense that is a felony under either state or federal law, unless the individual completes any imposed sentence two or more years before the day on which the individual submits the application.
(5) An eligible applicant for a medical cannabis caregiver card shall:
(a) submit an application for a medical cannabis caregiver card to the department through an electronic application connected to the state electronic verification system; and
(b) submit the following information in the application described in Subsection (5)(a):
(i) the applicant's name, gender, age, and address;
(ii) the name, gender, age, and address of the cardholder described in Section 26-61a-201 who designated the applicant; and
(iii) if a medical cannabis guardian cardholder designated the caregiver, the name, gender, and age of the minor receiving a medical cannabis treatment in relation to the medical cannabis guardian cardholder.
(6) Except as provided in Subsection (6)(b), a medical cannabis caregiver card that the department issues under this section is valid for the lesser of:
(a) an amount of time that the cardholder described in Section 26-61a-201 who designated the caregiver determines; or
(b) the amount of time remaining before the card of the cardholder described in Section 26-61a-201 expires.
(7)
(a) If a designated caregiver meets the requirements of Subsection (4), the designated caregiver's medical cannabis caregiver card renews automatically at the time the cardholder described in Section 26-61a-201 who designated the caregiver:
(i) renews the cardholder's card; and
(ii) renews the caregiver's designation, in accordance with Subsection (7)(b).
(b) The department shall provide a method in the card renewal process to allow a cardholder described in Section 26-61a-201 who has designated a caregiver to:
(i) signify that the cardholder renews the caregiver's designation;
(ii) remove a caregiver's designation; or
(iii) designate a new caregiver.
(8) The department may revoke a medical cannabis caregiver card if the designated caregiver:

(a) violates this chapter; or
(b) is convicted under state or federal law of:
(i) a felony; or
(ii) after the effective date of this bill, a misdemeanor for drug distribution.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-203 Designated caregiver -- Guardian -- Criminal background check.

(1) Each applicant for a medical cannabis guardian card under Section 26-61a-201 or a medical cannabis caregiver card under Section 26-61a-202 shall:
(a) submit to the department, at the time of application:
(i) a fingerprint card in a form acceptable to the Department of Public Safety; and
(ii) a signed waiver in accordance with Subsection 53-10-108(4) acknowledging the registration of the applicant's fingerprints in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service; and
(b) consent to a fingerprint background check by:
(i) the Bureau of Criminal Identification; and
(ii) the Federal Bureau of Investigation.
(2) The Bureau of Criminal Identification shall:
(a) check the fingerprints the applicant submits under Subsection (1)(a) against the applicable state, regional, and national criminal records databases, including the Federal Bureau of Investigation Next Generation Identification System;
(b) report the results of the background check to the department;
(c) maintain a separate file of fingerprints that applicants submit under Subsection (1)(a) for search by future submissions to the local and regional criminal records databases, including latent prints;
(d) request that the fingerprints be retained in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service for search by future submissions to national criminal records databases, including the Next Generation Identification System and latent prints; and
(e) establish a privacy risk mitigation strategy to ensure that the department only receives notifications for an individual with whom the department maintains an authorizing relationship.
(3) The department shall:
(a) assess an applicant who submits fingerprints under Subsection (1)(a) a fee in an amount that the department sets in accordance with Section 63J-1-504 for the services that the Bureau of Criminal Identification or another authorized agency provides under this section; and
(b) remit the fee described in Subsection (3)(a) to the Bureau of Criminal Identification.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-204 Medical cannabis card -- Patient and designated caregiver requirements -- Rebuttable presumption.

(1)
(a) A medical cannabis cardholder who possesses cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form that the cardholder purchased under this chapter shall:
(i) carry at all times the cardholder's medical cannabis card;

(ii) carry, with the cannabis in a medicinal dosage form or cannabis product in a medicinal dosage form, a label that identifies that the cannabis or cannabis product:
(A) was sold from a licensed medical cannabis pharmacy or the state central fill medical cannabis pharmacy; and
(B) includes an identification number that links the cannabis or cannabis product to the inventory control system; and
(iii) possess not more than:
(A) 113 grams of unprocessed cannabis; or
(B) an amount of cannabis product that contains 20 grams of total composite tetrahydrocannabinol.
(b) A medical cannabis cardholder who possesses cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form in violation of Subsection (1)(a) is:
(i) guilty of an infraction; and
(ii) subject to a $100 fine.
(c) A medical cannabis cardholder who possesses between 113 and 226 grams of unprocessed cannabis or a total amount of cannabis product that contains between 20 and 40 grams of total composite tetrahydrocannabinol is:
(i) guilty of a class B misdemeanor; and
(ii) subject to a fine of $1,000.
(d) An individual who is guilty of a violation described in Subsection (1)(b) or (c) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the penalty described in Subsection (1)(b) or (c).
(e) A medical cannabis cardholder who possesses more than 226 grams of unprocessed cannabis or a total amount of cannabis product that contains more than 40 grams of total composite tetrahydrocannabinol is subject to the penalties described in Title 58, Chapter 37, Utah Controlled Substances Act.
(2)
(a) As used in this Subsection (2), "emergency medical condition" means the same as that term is defined in Section 31A-22-627.
(b) Except as described in Subsection (2)(c), a medical cannabis patient cardholder or a provisional patient cardholder may not use, in public view, cannabis or a cannabis product.
(c) In the event of an emergency medical condition, an individual described in Subsection (2)(b) may use, and the holder of a medical cannabis guardian card or a medical cannabis caregiver card may administer to the cardholder's charge, in public view, cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form.
(3) If a medical cannabis cardholder carrying the cardholder's card possesses cannabis in a medicinal dosage form or a cannabis product in compliance with Subsection (1), or a medical cannabis device that corresponds with the cannabis or cannabis product:
(a) there is a rebuttable presumption that the cardholder possesses the cannabis, cannabis product, or medical cannabis device legally; and
(b) there is no probable cause, based solely on the cardholder's possession of the cannabis in medicinal dosage form, cannabis product in medicinal dosage form, or medical cannabis device, to believe that the cardholder is engaging in illegal activity.
(4)
(a) If a law enforcement officer stops an individual who possesses cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device, and the individual represents to the law enforcement officer that the individual holds a valid medical cannabis card, but the individual does not have the medical cannabis card

in the individual's possession at the time of the stop by the law enforcement officer, the law enforcement officer shall attempt to access the state electronic verification system to determine whether the individual holds a valid medical cannabis card.

(b) If the law enforcement officer is able to verify that the individual described in Subsection (4)(a) is a valid medical cannabis cardholder, the law enforcement officer:

(i) may not arrest or take the individual into custody for the sole reason that the individual is in possession of cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device; and

(ii) may not seize the cannabis, cannabis product, or medical cannabis device.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-205 Lost or stolen medical cannabis card.

(1) If a medical cannabis card is lost or stolen, the medical cannabis cardholder shall report the lost or stolen card to the department.

(2) Upon receiving the report described in Subsection (1), the department shall designate the medical cannabis card as lost or stolen in the state electronic verification system.

(3) A medical cannabis pharmacy agent or a local health department distribution agent may confiscate a medical cannabis card that is designated as lost or stolen in accordance with Subsection (2) if an individual presents the card at the relevant medical cannabis pharmacy or local health department.

(4) To request a new medical cannabis card, the medical cannabis cardholder described in Subsection (1) shall:

(a) complete a form that the department designates; and

(b) pay a fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

Enacted by Chapter 1, 2018 Special Session 3

Part 3
Medical Cannabis Pharmacy License

26-61a-301 Medical cannabis pharmacy -- License -- Eligibility.

(1) A person may not operate as a medical cannabis pharmacy without a license that the department issues under this part.

(2)

(a) Subject to Subsections (4) and (5) and to Section 26-61a-305, the department shall, in accordance with Title 63G, Chapter 6a, Utah Procurement Code, issue a license to operate a medical cannabis pharmacy to an applicant who is eligible for a license under this section.

(b) An applicant is eligible for a license under this section if the applicant submits to the department:

(i) subject to Subsection (2)(c), a proposed name and address where the applicant will operate the medical cannabis pharmacy;

(ii) the name and address of an individual who:

(A) has a financial or voting interest of 2% or greater in the proposed medical cannabis pharmacy; or

(B) has the power to direct or cause the management or control of a proposed cannabis production establishment;

(iii) evidence that the applicant has obtained and maintains a performance bond that a surety authorized to transact surety business in the state issues in an amount of at least $125,000 for each application that the applicant submits to the department;

(iv) an operating plan that:

(A) complies with Section 26-61a-304; and

(B) includes operating procedures to comply with the operating requirements for a medical cannabis pharmacy described in this chapter and with a relevant municipal or county law that is consistent with Section 26-61a-507;

(v) if the municipality or county where the proposed medical cannabis pharmacy would be located requires a local land use permit, a copy of the person's approved application for the local land use permit; and

(vi) an application fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

(c)

(i) A person may not locate a medical cannabis pharmacy in or within 600 feet of an area that the relevant municipality or county has zoned as primarily residential.

(ii) An applicant for a license under this section shall provide evidence of compliance with the proximity requirement described in Subsection (2)(c)(i).

(d) Except as provided in Subsection (2)(c), a medical cannabis pharmacy is a permitted use in all zoning districts within a municipality or county.

(e) If the department receives more than one application for a medical cannabis pharmacy within the same city or town, the department shall consult with the local land use authority before approving any of the applications pertaining to that city or town.

(3) If the department determines that an applicant is eligible for a license under this section, the department shall:

(a) charge the applicant an initial license fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504; and

(b) notify the Department of Public Safety of the license approval and the names of each individual described in Subsection (2)(b)(ii).

(4) The department may not issue a license to operate a medical cannabis pharmacy to an applicant if an individual described in Subsection (2)(b)(ii):

(a) has been convicted under state or federal law of:

(i) a felony; or

(ii) after the effective date of this bill, a misdemeanor for drug distribution; or

(b) is younger than 21 years old.

(5) If an applicant for a medical cannabis pharmacy license under this section holds a license under Title 4, Chapter 41, Hemp and Cannabinoid Act, or Title 4, Chapter 41a, Cannabis Production Establishments, the department:

(a) shall consult with the Department of Agriculture and Food regarding the applicant; and

(b) may not give preference to the applicant based on the applicant's status as a holder of a license described in this Subsection (5).

(6) The department may revoke a license under this part if:

(a) the medical cannabis pharmacy does not begin operations within one year after the day on which the department issues the initial license;

(b) the medical cannabis pharmacy makes the same violation of this chapter three times; or

(c) an individual described in Subsection (2)(b)(ii) is convicted, while the license is active, under state or federal law of:
(i) a felony; or
(ii) after the effective date of this bill, a misdemeanor for drug distribution.
(7) The department shall deposit the proceeds of a fee imposed by this section in the Qualified Patient Enterprise Fund.
(8) The department shall begin accepting applications under this part on or before March 1, 2020.
(9) The department's authority to issue a license under this section is plenary and is not subject to review.

Amended by Chapter 136, 2019 General Session

26-61a-302 Medical cannabis pharmacy owners and directors -- Criminal background checks.
(1) Each applicant for a license as a medical cannabis pharmacy shall submit, at the time of application, from each individual who has a financial or voting interest of 2% or greater in the applicant or who has the power to direct or cause the management or control of the applicant:
(a) a fingerprint card in a form acceptable to the Department of Public Safety;
(b) a signed waiver in accordance with Subsection 53-10-108(4) acknowledging the registration of the individual's fingerprints in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service; and
(c) consent to a fingerprint background check by:
(i) the Bureau of Criminal Identification; and
(ii) the Federal Bureau of Investigation.
(2) The Bureau of Criminal Identification shall:
(a) check the fingerprints the applicant submits under Subsection (1) against the applicable state, regional, and national criminal records databases, including the Federal Bureau of Investigation Next Generation Identification System;
(b) report the results of the background check to the department;
(c) maintain a separate file of fingerprints that applicants submit under Subsection (1) for search by future submissions to the local and regional criminal records databases, including latent prints;
(d) request that the fingerprints be retained in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service for search by future submissions to national criminal records databases, including the Next Generation Identification System and latent prints; and
(e) establish a privacy risk mitigation strategy to ensure that the department only receives notifications for an individual with whom the department maintains an authorizing relationship.
(3) The department shall:
(a) assess an individual who submits fingerprints under Subsection (1) a fee in an amount that the department sets in accordance with Section 63J-1-504 for the services that the Bureau of Criminal Identification or another authorized agency provides under this section; and
(b) remit the fee described in Subsection (3)(a) to the Bureau of Criminal Identification.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-303 Renewal.
(1) The department shall renew a license under this part every year if, at the time of renewal:

(a) the licensee meets the requirements of Section 26-61a-301; and
(b) the licensee pays the department a license renewal fee in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

(2)
(a) If a licensed medical cannabis pharmacy abandons the medical cannabis pharmacy's license, the department shall publish notice of an available license:
(i) in a newspaper of general circulation for the geographic area in which the medical cannabis pharmacy license is available; or
(ii) on the Utah Public Notice Website established in Section 63F-1-701.
(b) The department may establish criteria, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to identify the medical cannabis pharmacy actions that constitute abandonment of a medical cannabis pharmacy license.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-304 Operating plan.

A person applying for a medical cannabis pharmacy license shall submit to the department a proposed operation plan for the medical cannabis pharmacy that complies with this section and that includes:

(1) a description of the physical characteristics of the proposed facility, including a floor plan and an architectural elevation;
(2) a description of the credentials and experience of:
(a) each officer, director, or owner of the proposed medical cannabis pharmacy; and
(b) any highly skilled or experienced prospective employee;
(3) the medical cannabis pharmacy's employee training standards;
(4) a security plan;
(5) a description of the medical cannabis pharmacy's inventory control system, including a plan to make the inventory control system compatible with the state electronic verification system; and
(6) storage protocols, both short- and long-term, to ensure that cannabis is stored in a manner that is sanitary and preserves the integrity of the cannabis.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-305 Maximum number of licenses.

(1)
(a) Except as provided in Subsection (1)(b), the department may not issue more than seven medical cannabis pharmacy licenses.
(b)
(i) In addition to the licenses described in Subsection (1)(a), the department shall issue an eighth license if the state central fill medical cannabis pharmacy:
(A) is not operational by January 1, 2021; or
(B) ceases operations after January 1, 2021.
(ii) In addition to the licenses described in Subsections (1)(a) and (1)(b)(i), the department shall issue a ninth license if the state central fill medical cannabis pharmacy:
(A) is not operational by July 1, 2021; or
(B) ceases operations after July 1, 2021.

(iii) In addition to the licenses described in Subsections (1)(a), (1)(b)(i), and (1)(b)(ii), the department shall issue a tenth license if the state central fill medical cannabis pharmacy:
(A) is not operational by January 1, 2022; or
(B) ceases operations after January 1, 2022.
(iv) The department shall issue the licenses described in Subsection (1)(b)(i), (ii), and (iii), if a final order of a court enjoins or invalidates the operation of the state central fill medical cannabis pharmacy.
(2) If there are more qualified applicants than there are available licenses for medical cannabis pharmacies, the department shall:
(a) evaluate each applicant and award the license to the applicant that best demonstrates:
(i) experience with establishing and successfully operating a business that involves complying with a regulatory environment, tracking inventory, and training, evaluating, and monitoring employees;
(ii) an operating plan that will best ensure the safety and security of patrons and the community;
(iii) positive connections to the local community;
(iv) the suitability of the proposed location and the location's accessibility for qualifying patients; and
(v) the extent to which the applicant can reduce the cost of cannabis or cannabis products for patients; and
(b) ensure a geographic dispersal among licensees that is sufficient to reasonably maximize access to the largest number of medical cannabis cardholders.
(3) The department may conduct a face-to-face interview with an applicant for a license that the department evaluates under Subsection (2).

Renumbered and Amended by Chapter 1, 2018 Special Session 3

Part 4
Medical Cannabis Pharmacy Agents

26-61a-401 Medical cannabis pharmacy agent -- Registration.
(1) An individual may not serve as a medical cannabis pharmacy agent of a medical cannabis pharmacy unless the department registers the individual as a medical cannabis pharmacy agent.
(2) Except as provided in Section 26-61a-403, the following individuals, regardless of the individual's status as a qualified medical provider, may not act as a medical cannabis pharmacy agent, have a financial or voting interest of 2% or greater in a medical cannabis pharmacy, or have the power to direct or cause the management or control of a medical cannabis pharmacy:
(a) an advanced practice registered nurse licensed under Title 58, Chapter 31b, Nurse Practice Act;
(b) a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; or
(c) a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant Act.
(3)
(a) The department shall, within 15 days after the day on which the department receives a complete application from a medical cannabis pharmacy on behalf of a prospective medical

cannabis pharmacy agent, register and issue a medical cannabis pharmacy agent registration card to the prospective agent if the medical cannabis pharmacy:

(i) provides to the department:

(A) the prospective agent's name and address;

(B) the name and location of the licensed medical cannabis pharmacy where the prospective agent seeks to act as the medical cannabis pharmacy agent; and

(C) the submission required under Subsection (3)(b); and

(ii) pays a fee to the department in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

(b) Each prospective agent described in Subsection (3)(a) shall:

(i) submit to the department:

(A) a fingerprint card in a form acceptable to the Department of Public Safety; and

(B) a signed waiver in accordance with Subsection 53-10-108(4) acknowledging the registration of the prospective agent's fingerprints in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service; and

(ii) consent to a fingerprint background check by:

(A) the Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) The Bureau of Criminal Identification shall:

(i) check the fingerprints the prospective agent submits under Subsection (3)(b) against the applicable state, regional, and national criminal records databases, including the Federal Bureau of Investigation Next Generation Identification System;

(ii) report the results of the background check to the department;

(iii) maintain a separate file of fingerprints that prospective agents submit under Subsection (3)(b) for search by future submissions to the local and regional criminal records databases, including latent prints;

(iv) request that the fingerprints be retained in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service for search by future submissions to national criminal records databases, including the Next Generation Identification System and latent prints; and

(v) establish a privacy risk mitigation strategy to ensure that the department only receives notifications for an individual with whom the department maintains an authorizing relationship.

(d) The department shall:

(i) assess an individual who submits fingerprints under Subsection (3)(b) a fee in an amount that the department sets in accordance with Section 63J-1-504 for the services that the Bureau of Criminal Identification or another authorized agency provides under this section; and

(ii) remit the fee described in Subsection (3)(d)(i) to the Bureau of Criminal Identification.

(4) The department shall designate, on an individual's medical cannabis pharmacy agent registration card the name of the medical cannabis pharmacy where the individual is registered as an agent.

(5) A medical cannabis pharmacy agent shall comply with a certification standard that the department develops in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy, or a third-party certification standard that the department designates by rule, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(6) The department shall ensure that the certification standard described in Subsection (5) includes training in:
(a) Utah medical cannabis law; and
(b) medical cannabis pharmacy best practices.
(7) The department may revoke the medical cannabis pharmacy agent registration card of, or refuse to issue a medical cannabis pharmacy agent registration card to, an individual who:
(a) violates the requirements of this chapter; or
(b) is convicted under state or federal law of:
(i) a felony; or
(ii) after the effective date of this bill, a misdemeanor for drug distribution.
(8)
(a) A medical cannabis pharmacy agent registration card expires two years after the day on which the department issues or renews the card.
(b) A medical cannabis pharmacy agent may renew the agent's registration card if the agent:
(i) is eligible for a medical cannabis pharmacy agent registration card under this section;
(ii) certifies to the department in a renewal application that the information in Subsection (3)(a) is accurate or updates the information; and
(iii) pays to the department a renewal fee in an amount that:
(A) subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504; and
(B) may not exceed the cost of the relatively lower administrative burden of renewal in comparison to the original application process.

Amended by Chapter 136, 2019 General Session

26-61a-402 Medical cannabis pharmacy agent registration card -- Rebuttable presumption.
(1) A medical cannabis pharmacy agent shall carry the individual's medical cannabis pharmacy agent registration card with the individual at all times when:
(a) the individual is on the premises of a medical cannabis pharmacy; and
(b) the individual is transporting cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device between a cannabis production establishment and a medical cannabis pharmacy.
(2) If an individual handling, at a medical cannabis pharmacy, cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device or transporting cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device, possesses the cannabis, cannabis product, or medical cannabis device in compliance with Subsection (1):
(a) there is a rebuttable presumption that the individual possesses the cannabis, cannabis product, or medical cannabis device legally; and
(b) there is no probable cause, based solely on the individual's possession of the cannabis in medicinal dosage form, cannabis product in medicinal dosage form, or medical cannabis device in compliance with Subsection (1), that the individual is engaging in illegal activity.
(3)
(a) A medical cannabis pharmacy agent who fails to carry the agent's medical cannabis pharmacy agent registration card in accordance with Subsection (1) is:
(i) for a first or second offense in a two-year period:
(A) guilty of an infraction; and
(B) is subject to a $100 fine; or

(ii) for a third or subsequent offense in a two-year period:
(A) guilty of a class C misdemeanor; and
(B) subject to a $750 fine.

(b)
(i) The prosecuting entity shall notify the department and the relevant medical cannabis pharmacy of each conviction under Subsection (3)(a).
(ii) For each violation described in Subsection (3)(a)(ii), the department may assess the relevant medical cannabis pharmacy a fine of up to $5,000, in accordance with a fine schedule that the department establishes by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(c) An individual who is guilty of a violation described in Subsection (3)(a) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (3)(a).

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-403 Pharmacy medical providers -- Registration -- Continuing education.

(1)
(a) A medical cannabis pharmacy:
(i) shall employ a pharmacist who is licensed under Title 58, Chapter 17b, Pharmacy Practice Act, as a pharmacy medical provider;
(ii) may employ a physician who has the authority to write a prescription and is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, as a pharmacy medical provider;
(iii) shall ensure that a pharmacy medical provider described in Subsection (1)(a)(i) works onsite during all business hours; and
(iv) shall designate one pharmacy medical provider described in Subsection (1)(a)(i) as the pharmacist-in-charge to oversee the operation of and generally supervise the medical cannabis pharmacy.

(b) An individual may not serve as a pharmacy medical provider unless the department registers the individual as a pharmacy medical provider in accordance with Subsection (2).

(2)
(a) The department shall, within 15 days after the day on which the department receives an application from a medical cannabis pharmacy on behalf of a prospective pharmacy medical provider, register and issue a pharmacy medical provider registration card to the prospective pharmacy medical provider if the medical cannabis pharmacy:
(i) provides to the department:
(A) the prospective pharmacy medical provider's name and address;
(B) the name and location of the licensed medical cannabis pharmacy where the prospective pharmacy medical provider seeks to act as a pharmacy medical provider;
(C) a report detailing the completion of the continuing education requirement described in Subsection (3); and
(D) evidence that the prospective pharmacy medical provider is a pharmacist who is licensed under Title 58, Chapter 17b, Pharmacy Practice Act, or a physician who has the authority to write a prescription and is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; and
(ii) pays a fee to the department in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

(b) The department may not register a qualified medical provider or a state central fill medical provider as a pharmacy medical provider.

(3)

(a) A pharmacy medical provider shall complete the continuing education described in this Subsection (3) in the following amounts:

(i) as a condition precedent to registration, four hours; and

(ii) as a condition precedent to renewal of the registration, four hours every two years.

(b) In accordance with Subsection (3)(a), the pharmacy medical provider shall:

(i) complete continuing education:

(A) regarding the topics described in Subsection (3)(d); and

(B) offered by the department under Subsection (3)(c) or an accredited or approved continuing education provider that the department recognizes as offering continuing education appropriate for the medical cannabis pharmacy practice; and

(ii) make a continuing education report to the department in accordance with a process that the department establishes by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in collaboration with the Division of Occupational and Professional Licensing and:

(A) for a pharmacy medical provider who is licensed under Title 58, Chapter 17b, Pharmacy Practice Act, the Board of Pharmacy;

(B) for a pharmacy medical provider licensed under Title 58, Chapter 67, Utah Medical Practice Act, the Physicians Licensing Board; and

(C) for a pharmacy medical provider licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, the Osteopathic Physician and Surgeon's Licensing Board.

(c) The department may, in consultation with the Division of Occupational and Professional Licensing, develop the continuing education described in this Subsection (3).

(d) The continuing education described in this Subsection (3) may discuss:

(i) the provisions of this chapter;

(ii) general information about medical cannabis under federal and state law;

(iii) the latest scientific research on the endocannabinoid system and medical cannabis, including risks and benefits;

(iv) recommendations for medical cannabis as it relates to the continuing care of a patient in pain management, risk management, potential addiction, and palliative care; or

(v) best practices for recommending the form and dosage of a medical cannabis product based on the qualifying condition underlying a medical cannabis recommendation.

(4)

(a) A pharmacy medical provider registration card expires two years after the day on which the department issues or renews the card.

(b) A pharmacy medical provider may renew the provider's registration card if the provider:

(i) is eligible for a pharmacy medical provider registration card under this section;

(ii) certifies to the department in a renewal application that the information in Subsection (2)(a) is accurate or updates the information;

(iii) submits a report detailing the completion of the continuing education requirement described in Subsection (3); and

(iv) pays to the department a renewal fee in an amount that:

(A) subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504; and

(B) may not exceed the cost of the relatively lower administrative burden of renewal in comparison to the original application process.

Enacted by Chapter 1, 2018 Special Session 3

Part 5
Medical Cannabis Pharmacy Operation

26-61a-501 Operating requirements -- General.

(1)
(a) A medical cannabis pharmacy shall operate:
(i) at the physical address provided to the department under Section 26-61a-301; and
(ii) in accordance with the operating plan provided to the department under Section 26-61a-301 and, if applicable, 26-61a-304.
(b) A medical cannabis pharmacy shall notify the department before a change in the medical cannabis pharmacy's physical address or operating plan.

(2) An individual may not enter a medical cannabis pharmacy unless the individual:
(a) is at least 18 years old; and
(b) except as provided in Subsection (5), possesses a valid:
(i) medical cannabis pharmacy agent registration card; or
(ii) medical cannabis card.

(3) A medical cannabis pharmacy may not employ an individual who is younger than 21 years old.

(4) A medical cannabis pharmacy may not employ an individual who has been convicted of a felony under state or federal law.

(5) Notwithstanding Subsection (2), a medical cannabis pharmacy may authorize an individual who is not a medical cannabis pharmacy agent to access the medical cannabis pharmacy if the medical cannabis pharmacy tracks and monitors the individual at all times while the individual is at the medical cannabis pharmacy and maintains a record of the individual's access.

(6) A medical cannabis pharmacy shall operate in a facility that has:
(a) a single, secure public entrance;
(b) a security system with a backup power source that:
(i) detects and records entry into the medical cannabis pharmacy; and
(ii) provides notice of an unauthorized entry to law enforcement when the medical cannabis pharmacy is closed; and
(c) a lock on each area where the medical cannabis pharmacy stores cannabis or a cannabis product.

(7) A medical cannabis pharmacy shall post, both clearly and conspicuously in the medical cannabis pharmacy, the limit on the purchase of cannabis described in Subsection 26-61a-502(2).

(8) A medical cannabis pharmacy may not allow any individual to consume cannabis on the property or premises of the medical cannabis pharmacy.

(9) A medical cannabis pharmacy may not sell cannabis or a cannabis product without first indicating on the cannabis or cannabis product label the name of the medical cannabis pharmacy.

(10)
(a) Each medical cannabis pharmacy shall retain in the pharmacy's records the following information regarding each recommendation underlying a transaction:
(i) the qualified medical provider's name, address, and telephone number;

(ii) the patient's name and address;
(iii) the date of issuance;
(iv) dosing parameters or an indication that the qualified medical provider did not recommend specific dosing parameters; and
(v) if the patient did not complete the transaction, the name of the medical cannabis cardholder who completed the transaction.

(b) The medical cannabis pharmacy may not sell cannabis or a cannabis product unless the cannabis or cannabis product has a label securely affixed to the container indicating the following minimum information:
(i) the name, address, and telephone number of the medical cannabis pharmacy;
(ii) the unique identification number that the medical cannabis pharmacy assigns;
(iii) the date of the sale;
(iv) the name of the patient;
(v) the name of the qualified medical provider who recommended the medical cannabis treatment;
(vi) directions for use and cautionary statements, if any;
(vii) the amount dispensed and the cannabinoid content;
(viii) the beyond use date; and
(ix) any other requirements that the department determines, in consultation with the Division of Occupational and Professional Licensing and the Board of Pharmacy.

(11) A pharmacy medical provider or medical cannabis pharmacy agent shall:
(a) unless the medical cannabis cardholder has had a consultation under Subsection 26-61a-502(4), verbally offer to a medical cannabis cardholder at the time of a purchase of cannabis, a cannabis product, or a medical cannabis device, personal, face-to-face counseling with the pharmacy medical provider who is a pharmacist; and
(b) provide a telephone number or website by which the cardholder may contact a pharmacy medical provider for counseling.

(12)
(a) A medical cannabis pharmacy may create a medical cannabis disposal program that allows an individual to deposit unused or excess medical cannabis, cannabis residue from a medical cannabis device, or medical cannabis product in a locked box or other secure receptacle within the medical cannabis pharmacy.
(b) A medical cannabis pharmacy with a disposal program described in Subsection (12)(a) shall ensure that only a medical cannabis pharmacy agent can access deposited medical cannabis or medical cannabis products.
(c) A medical cannabis pharmacy shall dispose of any deposited medical cannabis or medical cannabis products by:
(i) rendering the deposited medical cannabis or medical cannabis products unusable and unrecognizable before transporting deposited medical cannabis or medical cannabis products from the medical cannabis pharmacy; and
(ii) disposing of the deposited medical cannabis or medical cannabis products in accordance with:
(A) federal and state law, rules, and regulations related to hazardous waste;
(B) the Resource Conservation and Recovery Act, 42 U.S.C. Sec. 6991 et seq.;
(C)Title 19, Chapter 6, Part 5, Solid Waste Management Act; and
(D) other regulations that the department makes in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(13) The department shall establish by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, protocols for a recall of cannabis and cannabis products by a medical cannabis pharmacy.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-502 Dispensing -- Amount a medical cannabis pharmacy may dispense -- Reporting -- Form of cannabis or cannabis product.

(1)
(a) A medical cannabis pharmacy may not sell a product other than, subject to this chapter:
(i) cannabis in a medicinal dosage form that the medical cannabis pharmacy acquired from a cannabis processing facility that is licensed under Section 4-41a-201;
(ii) a cannabis product in a medicinal dosage form that the medical cannabis pharmacy acquired from a cannabis processing facility that is licensed under Section 4-41a-201;
(iii) a medical cannabis device; or
(iv) educational material related to the medical use of cannabis.
(b) A medical cannabis pharmacy may only sell an item listed in Subsection (1)(a) to an individual with:
(i) a medical cannabis card; and
(ii) corresponding identification that is a valid United States federal- or state-issued photo identification, including a driver license, a United States passport, a United States passport card, or a United States military identification card.
(c) Notwithstanding Subsection (1)(a), a medical cannabis pharmacy may not sell a cannabis-based drug that the United States Food and Drug Administration has approved.
(2) A medical cannabis pharmacy may not dispense:
(a) to a medical cannabis cardholder in any one 12-day period, more than the lesser of:
(i) an amount sufficient to provide 14 days of treatment based on the dosing parameters that the relevant qualified medical provider recommends; or
(ii)
(A) 56 grams by weight of unprocessed cannabis that is in a medicinal dosage form and that carries a label clearly displaying the amount of tetrahydrocannabinol and cannabidiol in the cannabis; or
(B) an amount of cannabis products that is in a medicinal dosage form and that contains, in total, greater than 10 grams of total composite tetrahydrocannabinol;
(b) to a medical cannabis cardholder whose primary residence is located more than 100 miles from the nearest medical cannabis pharmacy or local health department, in any one 28-day period, more than the lesser of:
(i) an amount sufficient to provide 30 days of treatment based on the dosing parameters that the relevant qualified medical provider recommends; or
(ii)
(A) 113 grams by weight of unprocessed cannabis that is in a medicinal dosage form and that carries a label clearly displaying the amount of tetrahydrocannabinol and cannabidiol in the cannabis; or
(B) an amount of cannabis products that is in a medicinal dosage form and that contains, in total, greater than 20 grams of total composite tetrahydrocannabinol; or
(c) to an individual whose qualified medical provider did not recommend dosing parameters, until the individual consults with the pharmacy medical provider in accordance with Subsection (4), any cannabis or cannabis products.

(3) An individual with a medical cannabis card may not purchase:
(a) more cannabis or cannabis products than the amounts designated in Subsection (2) in any one 12-day period; or
(b) if the relevant qualified medical provider did not recommend dosing parameters, until the individual consults with the pharmacy medical provider in accordance with Subsection (4), any cannabis or cannabis products.
(4) If a qualified medical provider recommends treatment with medical cannabis or a cannabis product but does not provide dosing parameters:
(a) the qualified medical provider shall document in the recommendation:
(i) an evaluation of the qualifying condition underlying the recommendation;
(ii) prior treatment attempts with cannabis and cannabis products; and
(iii) the patient's current medication list; and
(b) before the relevant medical cannabis cardholder may obtain cannabis in a medicinal dosage form or a cannabis product in a medicinal dosage form, the pharmacy medical provider shall:
(i) review pertinent medical records, including the qualified medical provider documentation described in Subsection (4)(a); and
(ii) after completing the review described in Subsection (4)(b)(i) and consulting with the recommending qualified medical provider as needed, determine the best course of treatment through consultation with the cardholder regarding:
(A) the patient's qualifying condition underlying the recommendation from the qualified medical provider;
(B) indications for available treatments;
(C) dosing parameters; and
(D) potential adverse reactions.
(5) A medical cannabis pharmacy shall:
(a)
(i) access the state electronic verification system before dispensing cannabis or a cannabis product to a medical cannabis cardholder in order to determine if the cardholder or, where applicable, the associated patient has met the maximum amount of cannabis or cannabis products described in Subsection (2); and
(ii) if the verification in Subsection (5)(a)(i) indicates that the individual has met the maximum amount described in Subsection (2):
(A) decline the sale; and
(B) notify the qualified medical provider who made the underlying recommendation;
(b) submit a record to the state electronic verification system each time the medical cannabis pharmacy dispenses cannabis or a cannabis product to a medical cannabis cardholder;
(c) package any cannabis or cannabis product that is in a blister pack in a container that:
(i) complies with Subsection 4-41a-602(2);
(ii) is tamper-resistant and tamper-evident; and
(iii) opaque; and
(d) for a product that is a cube that is designed for ingestion through chewing or holding in the mouth for slow dissolution, include a separate, off-label warning about the risks of over-consumption.
(6)
(a) Except as provided in Subsection (6)(b), a medical cannabis pharmacy may not sell medical cannabis in the form of a cigarette or a medical cannabis device that is intentionally designed or constructed to resemble a cigarette.

(b) A medical cannabis pharmacy may sell a medical cannabis device that warms cannabis material into a vapor without the use of a flame and that delivers cannabis to an individual's respiratory system.

(7) A medical cannabis pharmacy may not give, at no cost, a product that the medical cannabis pharmacy is allowed to sell under Subsection (1).

(8) The department may impose a uniform fee on each medical cannabis cardholder transaction in a medical cannabis pharmacy in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-503 Partial filling.

(1) As used in this section, "partially fill" means to provide less than the full amount of cannabis or cannabis product that the qualified medical provider recommends, if the qualified medical provider recommended specific dosing parameters.

(2) A pharmacy medical provider may partially fill a recommendation for a medical cannabis treatment at the request of the qualified medical provider who issued the medical cannabis treatment recommendation or the medical cannabis cardholder.

(3) The department shall make rules, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying how to record the date, quantity supplied, and quantity remaining of a partially filled medical cannabis treatment recommendation.

(4) A pharmacy medical provider who is a pharmacist may, upon the request of a medical cannabis cardholder, determine different dosing parameters, subject to the dosing limits in Subsection 26-61a-502(2), to fill the quantity remaining of a partially filled medical cannabis treatment recommendation if:

(a) the pharmacy medical provider determined dosing parameters for the partial fill under Subsection 26-61a-502(4); and

(b) the medical cannabis cardholder reports that:

(i) the partial fill did not substantially affect the qualifying condition underlying the medical cannabis recommendation; or

(ii) the patient experienced an adverse reaction to the partial fill or was otherwise unable to successfully use the partial fill.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-504 Inspections.

(1) Each medical cannabis pharmacy shall maintain the pharmacy's medical cannabis treatment recommendation files and other records in accordance with this chapter, department rules, and the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

(2) The department may inspect the records and facility of a medical cannabis pharmacy at any time during business hours in order to determine if the medical cannabis pharmacy complies with this chapter.

(3) An inspection under this section may include:

(a) inspection of a site, facility, vehicle, book, record, paper, document, data, or other physical or electronic information, or any combination of the above;

(b) questioning of any relevant individual; or

(c) inspection of equipment, an instrument, a tool, or machinery, including a container or label.
(4) In making an inspection under this section, the department may freely access any area and review and make copies of a book, record, paper, document, data, or other physical or electronic information, including financial data, sales data, shipping data, pricing data, and employee data.
(5) Failure to provide the department or the department's authorized agents immediate access to records and facilities during business hours in accordance with this section may result in:
(a) the imposition of a civil monetary penalty that the department sets in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
(b) license or registration suspension or revocation; or
(c) an immediate cessation of operations under a cease and desist order that the department issues.

Amended by Chapter 136, 2019 General Session

26-61a-505 Advertising.
(1) Except as provided in Subsections (2) and (3), a medical cannabis pharmacy may not advertise in any medium.
(2) A medical cannabis pharmacy may use signage on the outside of the medical cannabis pharmacy that includes only:
(a) the medical cannabis pharmacy's name and hours of operation; and
(b) a green cross.
(3) A medical cannabis pharmacy may maintain a website that includes information about:
(a) the location and hours of operation of the medical cannabis pharmacy;
(b) a product or service available at the medical cannabis pharmacy;
(c) personnel affiliated with the medical cannabis pharmacy;
(d) best practices that the medical cannabis pharmacy upholds; and
(e) educational material related to the medical use of cannabis.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-506 Cannabis, cannabis product, or medical cannabis device transportation.
(1) Only the following individuals may transport cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device under this chapter:
(a) a registered medical cannabis pharmacy agent;
(b) a registered state central fill agent;
(c) a courier for a state central fill shipment described in Section 26-61a-605; or
(d) a medical cannabis cardholder who is transporting a medical cannabis treatment that the cardholder is authorized to transport.
(2) Except for an individual with a valid medical cannabis card under this chapter who is transporting a medical cannabis treatment that the cardholder is authorized to transport, an individual described in Subsection (1) shall possess a transportation manifest that:
(a) includes a unique identifier that links the cannabis, cannabis product, or medical cannabis device to a relevant inventory control system;
(b) includes origin and destination information for cannabis, a cannabis product, or a medical cannabis device that the individual is transporting; and
(c) identifies the departure and arrival times and locations of the individual transporting the cannabis, cannabis product, or medical cannabis device.

(3)
(a) In addition to the requirements in Subsections (1) and (2), the department may establish by rule, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, requirements for transporting cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device to ensure that the cannabis, cannabis product, or medical cannabis device remains safe for human consumption.
(b) The transportation described in Subsection (3)(a) is limited to transportation:
(i) between a medical cannabis pharmacy and another medical cannabis pharmacy; and
(ii) between the state central fill medical cannabis pharmacy and:
(A) another state central fill medical cannabis pharmacy location; or
(B) a local health department.
(4)
(a) It is unlawful for a registered medical cannabis pharmacy agent, a registered state central fill agent, or a courier described in Section 26-61a-605 to make a transport described in this section with a manifest that does not meet the requirements of this section.
(b) Except as provided in Subsection (4)(d), an agent or courier who violates Subsection (4)(a) is:
(i) guilty of an infraction; and
(ii) subject to a $100 fine.
(c) An individual who is guilty of a violation described in Subsection (4)(b) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (4)(b).
(d) If the individual described in Subsection (4)(a) is transporting more cannabis, cannabis product, or medical cannabis devices than the manifest identifies, except for a de minimis administrative error:
(i) this chapter does not apply; and
(ii) the individual is subject to penalties under Title 58, Chapter 37, Utah Controlled Substances Act.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-507 Local control.
(1)
(a)
(i) Except as provided in Subsection (1)(a)(ii), to be eligible to obtain or maintain a license under Section 26-61a-301, a person shall demonstrate that the intended medical cannabis pharmacy location is located at least:
(A) 600 feet from a community location's property boundary following the shortest route of ordinary pedestrian travel;
(B) 200 feet from the patron entrance to the community location's property boundary; and
(C) 600 feet from an area zoned primarily residential.
(ii) A municipal or county land use authority may recommend in writing that the department waive the community location proximity requirement described in Subsection (1)(a)(i).
(b)
(i) A municipality or county may not deny or revoke a land use permit to operate a medical cannabis pharmacy on the sole basis that the applicant or medical cannabis pharmacy violates federal law regarding the legal status of cannabis.

(ii) A municipality or county may not deny or revoke a business license to operate a medical cannabis pharmacy on the sole basis that the applicant or medical cannabis pharmacy violates federal law regarding the legal status of cannabis.

(2) A municipality or county may enact an ordinance that:

(a) is not in conflict with this chapter; and

(b) governs the time, place, or manner of medical cannabis pharmacy operations in the municipality or county.

Amended by Chapter 136, 2019 General Session

Part 6
State Central Fill Medical Cannabis Pharmacy

26-61a-601 Department to establish state central fill medical cannabis pharmacy -- Duties -- Pharmacy medical provider registration -- Continuing education.

(1) On or before July 1, 2020, the department shall establish or contract to establish, in accordance with Title 63G, Chapter 6a, Utah Procurement Code, a state central fill medical cannabis pharmacy as described in this section.

(2) The state central fill medical cannabis pharmacy shall:

(a) procure cannabis that a cannabis processing facility processes into a medicinal dosage form;

(b) prepare cannabis in medicinal dosage form, a cannabis product in medicinal dosage form, or a medical cannabis device for shipment to a medical cannabis cardholder under a qualified medical provider's recommendation to address a qualifying condition;

(c) transport a state central fill shipment, in accordance with Section 26-61a-605, to the relevant local health department for distribution, in accordance with Section 26-61a-607; and

(d)

(i)

(A) if the state establishes the state central fill medical cannabis pharmacy, process and accept payment for a transaction involving a state central fill shipment; or

(B) if the state establishes the state central fill medical cannabis pharmacy by contract, process prepaid requests for a state central fill shipment from the department; and

(ii) deposit funds that the state central fill medical cannabis pharmacy collects under Subsection (2)(d)(i) into the Qualified Distribution Enterprise Fund created in Section 26-61a-110.

(3)

(a) An individual may not enter a state central fill medical cannabis pharmacy location unless:

(i) the individual is a state central fill agent or an employee of the state central fill medical cannabis pharmacy;

(ii) the individual is an employee of the department; or

(iii) a state central fill agent escorts the individual at all times.

(b) An individual who violates Subsection (3)(a) is:

(i) guilty of an infraction; and

(ii) subject to a $100 fine.

(c) An individual who is guilty of a violation described in Subsection (3)(b) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (3)(b).

(4)

(a) The state central fill medical cannabis pharmacy:
(i) shall employ at least one pharmacist who is licensed under Title 58, Chapter 17b, Pharmacy Practice Act, as a state central fill medical provider;
(ii) may employ a physician who has the authority to write a prescription and is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, as a state central fill medical provider;
(iii) shall ensure that a state central fill medical provider described in Subsection (4)(a)(i) works onsite at each location during all business hours;
(iv) shall designate one state central fill medical provider described in Subsection (4)(a)(i) as the pharmacist-in-charge, as that term is defined in Section 58-17b-102, to oversee the operation of and generally supervise the state central fill medical cannabis pharmacy; and
(v) may establish more than one location in which the state central fill medical cannabis pharmacy operates if the department determines, after an analysis of the current and anticipated market for cannabis in a medicinal dosage form and cannabis products in a medicinal dosage form, including costs and logistical issues in transportation of state central fill shipments, that multiple central fill locations are necessary to provide an adequate supply of state central fill shipments to local health departments for distribution to recipient medical cannabis cardholders.
(b) An individual may not serve as a state central fill medical provider unless the department registers the individual as a state central fill medical provider.
(5)
(a) The department shall, within 15 days after the day on which the department receives an application from the state central fill medical cannabis pharmacy on behalf of a prospective state central fill medical provider, register and issue a state central fill medical provider registration card to the prospective state central fill medical provider if the state central fill medical cannabis pharmacy provides to the department:
(i) the prospective state central fill medical provider's name and address; and
(ii) evidence that the prospective state central fill medical provider is:
(A) a pharmacist who is licensed under Title 58, Chapter 17b, Pharmacy Practice Act; or
(B) a physician who has the authority to write a prescription and is licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(b) The department may not register a qualified medical provider or a pharmacy medical provider as a state central fill medical provider.
(6)
(a) A state central fill medical provider shall complete the continuing education described in this Subsection (6) in the following amounts:
(i) as a condition precedent to registration, four hours; and
(ii) as a condition precedent to renewal, four hours every two years.
(b) In accordance with Subsection (6)(a), the state central fill medical provider shall:
(i) complete continuing education:
(A) regarding the topics described in Subsection (6)(d); and
(B) offered by the department under Subsection (6)(c) or an accredited or approved continuing education provider that the department recognizes as offering continuing education appropriate for the medical cannabis pharmacy practice; and
(ii) make a continuing education report to the department in accordance with a process that the department establishes by rule, in accordance with Title 63G, Chapter 3, Utah

Administrative Rulemaking Act, and in collaboration with the Division of Occupational and Professional Licensing and:

(A) for a state central fill medical provider who is licensed under Title 58, Chapter 17b, Pharmacy Practice Act, the Board of Pharmacy;

(B) for a state central fill medical provider licensed under Title 58, Chapter 67, Utah Medical Practice Act, the Physicians Licensing Board; and

(C) for a state central fill medical provider licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, the Osteopathic Physician and Surgeon's Licensing Board.

(c) The department may, in consultation with the Division of Occupational and Professional Licensing, develop the continuing education described in this Subsection (6).

(d) The continuing education described in this Subsection (6) may discuss:

(i) the provisions of this chapter;

(ii) general information about medical cannabis under federal and state law;

(iii) the latest scientific research on the endocannabinoid system and medical cannabis, including risks and benefits;

(iv) recommendations for medical cannabis as it relates to the continuing care of a patient in pain management, risk management, potential addiction, and palliative care; or

(v) best practices for recommending the form and dosage of medical cannabis products based on the qualifying condition underlying the medical cannabis recommendation.

(7)

(a) A state central fill medical provider registration card expires two years after the day on which the department issues or renews the card.

(b) A state central fill medical provider may renew the provider's registration card if the provider:

(i) is eligible for a state central fill medical provider registration card under this section;

(ii) certifies to the department in a renewal application that the information in Subsection (5) is accurate or updates the information; and

(iii) submits a report detailing the completion of the continuing education requirement described in Subsection (6).

Amended by Chapter 136, 2019 General Session

26-61a-602 State central fill agent -- Background check -- Registration card -- Rebuttable presumption.

(1) An individual may not serve as a state central fill agent unless:

(a) the individual is an employee of the state central fill medical cannabis pharmacy; and

(b) the department registers the individual as a state central fill agent.

(2)

(a) The department shall, within 15 days after the day on which the department receives a complete application from the state central fill medical cannabis pharmacy on behalf of a prospective state central fill agent, register and issue a state central fill agent registration card to the prospective agent if the state central fill medical cannabis pharmacy:

(i) provides to the department:

(A) the prospective agent's name and address; and

(B) the submission required under Subsection (2)(b); and

(ii) as reported under Subsection (2)(b), has not been convicted under state or federal law of:

(A) a felony; or

(B) after the effective date of this bill, a misdemeanor for drug distribution.

(b) Each prospective agent described in Subsection (2)(a) shall:
(i) submit to the department:
(A) a fingerprint card in a form acceptable to the Department of Public Safety; and
(B) a signed waiver in accordance with Subsection 53-10-108(4) acknowledging the registration of the prospective agent's fingerprints in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service; and
(ii) consent to a fingerprint background check by:
(A) the Bureau of Criminal Identification; and
(B) the Federal Bureau of Investigation.
(c) The Bureau of Criminal Identification shall:
(i) check the fingerprints the prospective agent submits under Subsection (2)(b) against the applicable state, regional, and national criminal records databases, including the Federal Bureau of Investigation Next Generation Identification System;
(ii) report the results of the background check to the department;
(iii) maintain a separate file of fingerprints that prospective agents submit under Subsection (2)(b) for search by future submissions to the local and regional criminal records databases, including latent prints;
(iv) request that the fingerprints be retained in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service for search by future submissions to national criminal records databases, including the Next Generation Identification System and latent prints; and
(v) establish a privacy risk mitigation strategy to ensure that the department only receives notifications for an individual with whom the department maintains an authorizing relationship.
(d) The department shall:
(i) assess an individual who submits fingerprints under Subsection (2)(b) a fee in an amount that the department sets in accordance with Section 63J-1-504 for the services that the Bureau of Criminal Identification or another authorized agency provides under this section; and
(ii) remit the fee described in Subsection (2)(d)(i) to the Bureau of Criminal Identification.
(3)
(a) A state central fill agent shall comply with a certification standard that the department develops, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy, or a third-party certification standard that the department designates by rule, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(b) The department shall ensure that the certification standard described in Subsection (3)(a) includes continuing education in:
(i) Utah medical cannabis law;
(ii) the state central fill medical cannabis pharmacy shipment process; and
(iii) state central fill agent best practices.
(4) The department may revoke or refuse to issue the state central fill agent registration card of an individual who:
(a) violates the requirements of this chapter; or
(b) is convicted under state or federal law of:
(i) a felony; or
(ii) after the effective date of this bill, a misdemeanor for drug distribution.

(5)
(a) A state central fill agent registration card expires two years after the day on which the department issues or renews the card.
(b) A state central fill agent may renew the agent's registration card if the agent:
(i) is eligible for a state central fill registration card under this section; and
(ii) certifies to the department in a renewal application that the information in Subsection (2)(a) is accurate or updates the information.
(6) A state central fill agent who the department registers under this section shall carry the individual's state central fill agent registration card with the individual at all times when:
(a) the individual is on the premises of the state central fill medical cannabis pharmacy; and
(b) the individual is transporting cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, or a medical cannabis device between a cannabis production establishment and the state central fill medical cannabis pharmacy.
(7) If an individual handling cannabis, a cannabis product, or a medical cannabis device handles the cannabis, cannabis product, or medical cannabis device in compliance with Subsection (6):
(a) there is a rebuttable presumption that the individual possesses the cannabis, cannabis product, or medical cannabis device legally; and
(b) there is no probable cause, based solely on the individual's handling of the cannabis in medicinal dosage form, cannabis product in medicinal dosage form, or medical cannabis device, that the individual is engaging in illegal activity.
(8)
(a) An individual who violates Subsection (6) is:
(i) guilty of an infraction; and
(ii) subject to a $100 fine.
(b) An individual who is guilty of a violation described in Subsection (8)(a) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (8)(a).

Amended by Chapter 136, 2019 General Session

26-61a-603 Recommendation.
(1) When an individual receives a recommendation for a medical cannabis treatment from the individual's qualified medical provider, the individual may initiate a shipment from the state central fill medical cannabis pharmacy to a local health department by:
(a) contacting the state central fill medical cannabis pharmacy directly; or
(b) requesting that the qualified medical provider initiate the shipment through the state electronic verification system.
(2) Upon receiving a request to prepare a shipment under Subsection (1), a state central fill agent shall:
(a) verify the shipment information using the state electronic verification system;
(b) process payment, including contacting the medical cannabis cardholder to complete payment if necessary;
(c) prepare the shipment in accordance with Section 26-61a-604;
(d) record the preparation of the shipment in the electronic verification system; and
(e) place the shipment for transportation in accordance with Section 26-61a-605.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-604 State central fill shipment preparation.

(1)

(a) The state central fill medical cannabis pharmacy may not prepare or ship to a local health department a product other than:

(i) cannabis in medicinal dosage form that the state central fill medical cannabis pharmacy acquired from a cannabis processing facility that is licensed under Section 4-41a-201;

(ii) a cannabis product in medicinal dosage form that the state central fill medical cannabis pharmacy acquired from a cannabis processing facility that is licensed under Section 4-41a-201;

(iii) a medical cannabis device; or

(iv) educational material related to the medical use of cannabis.

(b) The state central fill medical cannabis pharmacy may only sell or ship an item listed in Subsection (1)(a) in response to a request for shipment described in Subsection 26-61a-603(1).

(c) Notwithstanding Subsection (1)(a), the state central fill medical cannabis pharmacy may not sell a cannabis-based drug that the United States Food and Drug Administration has approved.

(2) The state central fill medical cannabis pharmacy may not prepare a shipment:

(a) for a medical cannabis cardholder in any one 12-day period, more than the lesser of:

(i) an amount sufficient to provide 14 days of treatment based on the dosing parameters that the relevant qualified medical provider recommends; or

(ii)

(A) 56 grams by weight of unprocessed cannabis that is in a medicinal dosage form and that carries a label clearly displaying the amount of tetrahydrocannabinol and cannabidiol in the cannabis; or

(B) an amount of cannabis products that is in a medicinal dosage form and that contains, in total, greater than 10 grams of total composite tetrahydrocannabinol;

(b) to a medical cannabis cardholder whose primary residence is located more than 100 miles from the nearest medical cannabis pharmacy or local health department, in any one 28-day period, more than the lesser of:

(i) an amount sufficient to provide 30 days of treatment based on the dosing parameters that the relevant qualified medical provider recommends; or

(ii)

(A) 113 grams by weight of unprocessed cannabis that is in a medicinal dosage form and that carries a label clearly displaying the amount of tetrahydrocannabinol and cannabidiol in the cannabis; or

(B) an amount of cannabis products that is in a medicinal dosage form and that contains, in total, greater than 20 grams of total composite tetrahydrocannabinol; or

(c) for an individual whose qualified medical provider did not recommend dosing parameters, any cannabis or cannabis product, until the individual consults with the state central fill medical provider in accordance with Subsection (4).

(3) A medical cannabis cardholder may not receive a state central fill shipment containing:

(a) more cannabis or cannabis products than the amounts designated in Subsection (2) in any one 12-day period; or

(b) if the relevant qualified medical provider did not recommend dosing parameters, any cannabis or cannabis product, until the cardholder consults with the state central fill medical provider in accordance with Subsection (4).

(4) If a qualified medical provider recommends treatment with medical cannabis or a cannabis product but does not provide dosing parameters:
(a) the qualified medical provider shall document in the recommendation:
(i) an evaluation of the qualifying condition underlying the recommendation;
(ii) prior treatment attempts with cannabis and cannabis products; and
(iii) the patient's current medication list; and
(b) before the relevant medical cannabis cardholder may receive a state central fill shipment, the state central fill medical provider shall:
(i) review pertinent medical records, including the qualified medical provider documentation described in Subsection (4)(a); and
(ii) after completing the review described in Subsection (4)(b)(i) and consulting with the recommending qualified medical provider as needed, determine the best course of treatment through consultation with the cardholder regarding:
(A) the patient's qualifying condition underlying the recommendation from the qualified medical provider;
(B) indications for available treatments;
(C) dosing parameters; and
(D) potential adverse reactions.
(5) The state central fill medical cannabis pharmacy shall:
(a)
(i) access the state electronic verification system before preparing a shipment of cannabis or a cannabis product to determine if the medical cannabis cardholder or, where applicable, the associated patient has met the maximum amount of cannabis or cannabis product described in Subsection (2); and
(ii) if the verification in Subsection (5)(a)(i) indicates that the individual has met the maximum amount described in Subsection (2):
(A) decline the request to prepare the shipment; and
(B) notify the qualified medical provider that made the recommendation;
(b) submit a record to the state electronic verification system each time the state central fill medical cannabis pharmacy prepares and ships a shipment of cannabis, a cannabis product, or a medical cannabis device;
(c) package any cannabis or cannabis product that is in a blister pack in a container that:
(i) complies with Subsection 4-41a-602(2);
(ii) is tamper-resistant and tamper-evident; and
(iii) is opaque; and
(d) for any product that is a cube that is designed for ingestion through chewing or holding in the mouth for slow dissolution, include a separate, off-label warning about the risks of over-consumption.
(6)
(a) Except as provided in Subsection (6)(b), the state central fill medical cannabis pharmacy may not sell medical cannabis in the form of a cigarette or a medical cannabis device that is intentionally designed or constructed to resemble a cigarette.
(b) The state central fill medical cannabis pharmacy may sell a medical cannabis device that warms cannabis material into a vapor without the use of a flame and that delivers cannabis to an individual's respiratory system.
(7) The state central fill medical cannabis pharmacy may not give, at no cost, a product that the medical cannabis pharmacy is allowed to sell under Subsection (1).
(8)

(a) The state central fill medical cannabis pharmacy shall retain in the pharmacy's records the following information regarding each recommendation underlying a transaction:
(i) the qualified medical provider's name, address, and telephone number;
(ii) the patient's name and address;
(iii) the date of issuance;
(iv) dosing parameters or an indication that the qualified medical provider did not recommend specific dosing parameters; and
(v) the name and the address of the medical cannabis cardholder if the cardholder is not the patient.
(b) The state central fill medical cannabis pharmacy may not sell cannabis or a cannabis product unless the cannabis or cannabis product has a label securely affixed to the container indicating the following minimum information:
(i) the name and telephone number of the state central fill medical cannabis pharmacy;
(ii) the unique identification number that the state central fill medical cannabis pharmacy assigns;
(iii) the date of the sale;
(iv) the name of the medical cannabis cardholder;
(v) the name of the qualified medical provider who recommends the medical cannabis treatment;
(vi) directions for use and cautionary statements, if any;
(vii) the amount dispensed and the cannabinoid content;
(viii) the beyond use date; and
(ix) any other requirements that the department determines, in consultation with the Division of Occupational and Professional Licensing and the Board of Pharmacy.
(9) A pharmacy medical provider at the state central fill medical cannabis pharmacy or a state central fill agent shall:
(a) include in each state central fill shipment written counseling regarding the state central fill shipment; and
(b) provide a telephone number or website by which a medical cannabis cardholder may contact a pharmacy medical provider for counseling.
(10) The department shall establish by rule, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, protocols for a recall of cannabis and cannabis products by the state central fill medical cannabis pharmacy.
(11) The department may impose a uniform fee on each medical cannabis cardholder transaction for a state central fill shipment in an amount that, subject to Subsection 26-61a-109(5), the department sets in accordance with Section 63J-1-504.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-605 State central fill shipment transportation.
(1) The state central fill medical cannabis pharmacy shall ensure that the state central fill medical cannabis pharmacy is capable of delivering, in a secure manner, cannabis in medicinal dosage form, a cannabis product in medicinal dosage form, and a medical cannabis device to each local health department in the state within two business days after the day on which the state central fill medical cannabis pharmacy receives a request for a state central fill shipment resulting from a recommendation of a qualified medical provider under Section 26-61a-603.
(2)

(a) The department may contract with a private entity for the entity to serve as a courier for the state central fill medical cannabis pharmacy, delivering state central fill shipments to local health departments for distribution to medical cannabis cardholders.
(b) If the department enters into a contract described in Subsection (2)(a), the department shall:
(i) issue the contract described in Subsection (2)(a) in accordance with Title 63G, Chapter 6a, Utah Procurement Code;
(ii) impose security and personnel requirements on the contracted private entity sufficient to ensure the security and safety of state central fill shipments; and
(iii) provide regular oversight of the contracted private entity.
(3) Except for an individual with a valid medical cannabis card who transports a shipment the individual receives, an individual may not transport a state central fill shipment unless the individual is:
(a) a registered state central fill agent; or
(b) an agent of the private courier described in Subsection (2).
(4) An individual transporting a state central fill shipment shall possess a transportation manifest that:
(a) includes a unique identifier that links the state central fill shipment to a relevant inventory control system;
(b) includes origin and destination information for a state central fill shipment the individual is transporting; and
(c) indicates the departure and arrival times and locations of the individual transporting the state central fill shipment.
(5) In addition to the requirements in Subsections (3) and (4), the department may establish by rule, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, requirements for transporting state central fill shipments that are related to safety for human consumption of cannabis or a cannabis product.
(6)
(a) It is unlawful for an individual to transport a state central fill shipment with a manifest that does not meet the requirements of Subsection (4).
(b) Except as provided in Subsection (6)(d), an individual who violates Subsection (6)(a) is:
(i) guilty of an infraction; and
(ii) subject to a $100 fine.
(c) An individual who is guilty of a violation described in Subsection (6)(b) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (6)(b).
(d) If the individual described in Subsection (6)(a) is transporting more cannabis, cannabis product, or medical cannabis devices than the manifest identifies, except for a de minimis administrative error:
(i) this chapter does not apply; and
(ii) the individual is subject to penalties under Title 58, Chapter 37, Utah Controlled Substances Act.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-606 Local health department distribution agent -- Background check -- Registration card -- Rebuttable presumption.
(1) An individual may not serve as a local health department distribution agent unless:

(a) the individual is an employee of a local health department; and
(b) the department registers the individual as a local health department distribution agent.
(2)
(a) The department shall, within 15 days after the day on which the department receives a complete application from a local health department on behalf of a prospective local health department distribution agent, register and issue a local health department distribution agent registration card to the prospective agent if the local health department:
(i) provides to the department:
(A) the prospective agent's name and address;
(B) the name and location of the local health department where the prospective agent seeks to act as a local health department distribution agent; and
(C) the submission required under Subsection (2)(b); and
(ii) as reported under Subsection (2)(c), has not been convicted under state or federal law of:
(A) a felony; or
(B) after the effective date of this bill, a misdemeanor for drug distribution.
(b) Each prospective agent described in Subsection (2)(a) shall:
(i) submit to the department:
(A) a fingerprint card in a form acceptable to the Department of Public Safety; and
(B) a signed waiver in accordance with Subsection 53-10-108(4) acknowledging the registration of the prospective agent's fingerprints in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service; and
(ii) consent to a fingerprint background check by:
(A) the Bureau of Criminal Identification; and
(B) the Federal Bureau of Investigation.
(c) The Bureau of Criminal Identification shall:
(i) check the fingerprints the prospective agent submits under Subsection (2)(b) against the applicable state, regional, and national criminal records databases, including the Federal Bureau of Investigation Next Generation Identification System;
(ii) report the results of the background check to the department;
(iii) maintain a separate file of fingerprints that prospective agents submit under Subsection (2)(b) for search by future submissions to the local and regional criminal records databases, including latent prints;
(iv) request that the fingerprints be retained in the Federal Bureau of Investigation Next Generation Identification System's Rap Back Service for search by future submissions to national criminal records databases, including the Next Generation Identification System and latent prints; and
(v) establish a privacy risk mitigation strategy to ensure that the department only receives notifications for an individual with whom the department maintains an authorizing relationship.
(d) The department shall:
(i) assess an individual who submits fingerprints under Subsection (2)(b) a fee in an amount that the department sets in accordance with Section 63J-1-504 for the services that the Bureau of Criminal Identification or another authorized agency provides under this section; and
(ii) remit the fee described in Subsection (2)(d)(i) to the Bureau of Criminal Identification.
(3) The department shall designate on an individual's local health department distribution agent registration card the name of the local health department where the individual is registered as an agent.

(4)
(a) A local health department distribution agent shall comply with a certification standard that the department develops, in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy, or a third-party certification standard that the department designates by rule in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(b) The department shall ensure that the certification standard described in Subsection (4)(a) includes training in:
(i) Utah medical cannabis law;
(ii) the state central fill medical cannabis pharmacy shipment process; and
(iii) local health department distribution agent best practices.
(5) The department may revoke or refuse to issue or renew the local health department distribution agent registration card of an individual who:
(a) violates the requirements of this chapter; or
(b) is convicted under state or federal law of:
(i) a felony; or
(ii) after the effective date of this bill, a misdemeanor for drug distribution.
(6) A local health department distribution agent who the department has registered under this section shall carry the agent's local health department distribution agent registration card with the agent at all times when:
(a) the agent is on the premises of the local health department; and
(b) the agent is handling a shipment of cannabis or cannabis product from the state central fill medical cannabis pharmacy.
(7) If a local health department distribution agent handling a shipment of cannabis or cannabis product from the state central fill medical cannabis pharmacy possesses the shipment in compliance with Subsection (6):
(a) there is a rebuttable presumption that the agent possesses the shipment legally; and
(b) there is no probable cause, based solely on the agent's possession of the shipment containing medical cannabis in medicinal dosage form, a cannabis product in medicinal dosage form, or a medical cannabis device, that the agent is engaging in illegal activity.
(8)
(a) A local health department distribution agent who violates Subsection (6) is:
(i) guilty of an infraction; and
(ii) subject to a $100 fine.
(b) An individual who is guilty of a violation described in Subsection (8)(a) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (8)(a).

Amended by Chapter 136, 2019 General Session

26-61a-607 Local health department distribution.
(1) Each local health department shall designate:
(a) one or more of the local health department's locations as a state central fill shipment distribution location; and
(b) a sufficient number of personnel to ensure that at least one individual is available at all times during business hours:
(i) whom the department has registered as a local health department distribution agent; and

(ii) to distribute state central fill shipments to medical cannabis cardholders in accordance with this section.

(2) An individual may not retrieve a shipment from the state central fill medical cannabis pharmacy at a local health department unless the individual presents:

(a) a form of identification that is a valid United States federal- or state-issued photo identification, including a driver license, a United States passport, a United States passport card, or a United States military identification card; and

(b) a valid medical cannabis card under the same name that appears on the identification described in Subsection (2)(a).

(3) Before a local health department distribution agent distributes a state central fill shipment to a medical cannabis cardholder, the local health department distribution agent shall:

(a) verify the shipment information using the state electronic verification system;

(b) ensure that the individual satisfies the identification requirements in Subsection (2);

(c) verify that payment is complete; and

(d) record the completion of the shipment transaction in the electronic verification system.

(4) The local health department shall:

(a)

(i) store each state central fill shipment that the local health department receives, until the recipient medical cannabis cardholder retrieves the shipment or the local health department returns the shipment to the state central fill medical cannabis pharmacy in accordance with Subsection (5), in a single, secure, locked area that is equipped with a security system that detects and records entry into the area; and

(ii) ensure that only a local health department distribution agent is able to access the area;

(b) return any unclaimed state central fill shipment to the state central fill medical cannabis pharmacy, in accordance with Subsection (5)(a), after the local health department has possessed the state central fill shipment for 10 business days; and

(c) return any state central fill shipment to the state central fill medical cannabis pharmacy, in accordance with Subsection (5)(b), if a medical cannabis cardholder returns the shipment to the local health department after retrieving the shipment.

(5)

(a) If a local health department returns an unclaimed state central fill shipment under Subsection (4)(b), the state central fill medical cannabis pharmacy may repackage or otherwise reuse the shipment for another state central fill shipment.

(b) If a local health department returns a returned state central fill shipment under Subsection (4)(c), the state central fill medical cannabis pharmacy shall dispose of the returned shipment by:

(i) rendering the state central fill shipment unusable and unrecognizable before transporting the shipment from the state central fill medical cannabis pharmacy; and

(ii) disposing of the state central fill shipment in accordance with:

(A) federal and state laws, rules, and regulations related to hazardous waste;

(B) the Resource Conservation and Recovery Act, 42 U.S.C. Sec. 6991 et seq.;

(C)Title 19, Chapter 6, Part 5, Solid Waste Management Act; and

(D) other regulations that the department makes in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-608 Department to set state central fill medical cannabis pharmacy prices.

(1) The department shall set a price schedule for cannabis in a medicinal dosage form that the state central fill medical cannabis pharmacy sells to medical cannabis cardholders through distribution to local health departments.
(2) The department shall ensure that the price schedule described in Subsection (1):
(a) through an annual review, takes into consideration:
(i) the demand for medical cannabis and cannabis products dispensed through the state central fill medical cannabis pharmacy and the local health departments;
(ii) the labor required to cultivate and process cannabis into a medicinal dosage form;
(iii) the regulatory burden involved in the creation of the product; and
(iv) any other consideration the department considers necessary; and
(b) after at least three medical cannabis pharmacies that the department licenses under Section 26-61a-301 are operational, contains pricing for a specific product that is within 10% of the average price for the product among the operational medical cannabis pharmacies.
(3) The department shall ensure that the price schedule that the department sets under Subsection (1) includes a set fee that the department deposits into the Qualified Distribution Enterprise Fund to cover the cost of:
(a) the state central fill medical cannabis pharmacy; and
(b) the courier described in Section 26-61a-605, if any.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-609 Partial filling.
(1) As used in this section, "partially fill" means to provide less than the full amount of cannabis or cannabis product that the qualified medical provider recommends, if the qualified medical provider recommended specific dosing parameters.
(2) The state central fill medical cannabis pharmacy may partially fill a recommendation for a medical cannabis treatment at the request of the qualified medical provider who issued the medical cannabis treatment recommendation or the medical cannabis cardholder.
(3) The department shall make rules in collaboration with the Division of Occupational and Professional Licensing and the Board of Pharmacy and in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specifying how to record the date, quantity supplied, and quantity remaining of a partially filled medical cannabis treatment recommendation.
(4) A state central fill medical provider who is a pharmacist may, upon the request of a medical cannabis cardholder, determine different dosing parameters, subject to the dosing limits in Subsection 26-61a-604(2), to fill the quantity remaining of a partially filled medical cannabis treatment recommendation if:
(a) the state central fill medical provider determined dosing parameters for the partial fill under Subsection 26-61a-604(4); and
(b) the medical cannabis cardholder reports that:
(i) the partial fill did not substantially affect the qualifying condition underlying the medical cannabis recommendation; or
(ii) the patient experienced an adverse reaction to the partial fill or was otherwise unable to successfully use the partial fill.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-610 Records -- Inspections.

(1) The state central fill medical cannabis pharmacy shall maintain the pharmacy's medical cannabis treatment recommendation files and other records in accordance with this chapter, department rules, and the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.
(2) The department may inspect the records and facility of the state central fill medical cannabis pharmacy or a local health department at any time during business hours in order to determine compliance with this chapter.
(3) An inspection under this section may include:
  (a) inspection of a site, facility, vehicle, book, record, paper, document, data, and other physical or electronic information;
  (b) questioning of any relevant individual; or
  (c) inspection of equipment, an instrument, a tool, or machinery, including a container or label.
(4) In making an inspection under this section, the department may freely access any area and review and make copies of a book, record, paper, document, data, or other physical or electronic information, including financial data, sales data, shipping data, pricing data, and employee data.
(5) Failure to provide the department or the department's authorized agents immediate access during business hours in accordance with this section may result in:
  (a) the imposition of a civil monetary penalty that the department sets in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
  (b) license or registration suspension or revocation; or
  (c) an immediate cessation of operations under a cease and desist order that the department issues.

Enacted by Chapter 1, 2018 Special Session 3

26-61a-611 Advertising.
(1) Except as provided in Subsection (2), the state central fill medical cannabis pharmacy may not advertise in any medium.
(2) The state central fill medical cannabis pharmacy may maintain a website that includes information about:
  (a) the contact information for the state central fill medical cannabis pharmacy;
  (b) a product or service available through shipment from the state central fill medical cannabis pharmacy;
  (c) a description of the state central fill medical cannabis pharmacy shipment process;
  (d) information about retrieving a state central fill shipment at a local health department; and
  (e) educational material related to the medical use of cannabis.

Amended by Chapter 136, 2019 General Session

Part 7
Enforcement

26-61a-701 Enforcement -- Misdemeanor.
(1) Except as provided in Title 4, Chapter 41a, Cannabis Production Establishments, and Sections 26-61a-502, 26-61a-605, and 26-61a-607, it is unlawful for a medical cannabis cardholder to

sell or otherwise give to another medical cannabis cardholder cannabis in a medicinal dosage form, a cannabis product in a medicinal dosage form, a medical cannabis device, or any cannabis residue remaining in or from a medical cannabis device.

(2)

(a) Except as provided in Subsection (2)(b), a medical cannabis cardholder who violates Subsection (1) is:

(i) guilty of a class B misdemeanor; and

(ii) subject to a $1,000 fine.

(b) An individual is not guilty under Subsection (2)(a) if the individual:

(i)

(A) is a designated caregiver; and

(B) gives the product described in Subsection (1) to the medical cannabis cardholder who designated the individual as a designated caregiver; or

(ii)

(A) is a medical cannabis guardian cardholder; and

(B) gives the product described in Subsection (1) to the relevant provisional patient cardholder.

(c) An individual who is guilty of a violation described in Subsection (2)(a) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (2)(a).

Enacted by Chapter 1, 2018 Special Session 3

26-61a-702 Enforcement -- Fine -- Citation.

(1)

(a) The department may, for a medical cannabis pharmacy's violation of this chapter:

(i) revoke the medical cannabis pharmacy license;

(ii) refuse to renew the medical cannabis pharmacy license; or

(iii) assess the medical cannabis pharmacy an administrative penalty.

(b) The department may, for a medical cannabis pharmacy agent's or state central fill agent's violation of this chapter:

(i) revoke the medical cannabis pharmacy agent or state central fill agent registration card;

(ii) refuse to renew the medical cannabis pharmacy agent or state central fill agent registration card; or

(iii) assess the medical cannabis pharmacy agent or state central fill agent an administrative penalty.

(2) The department shall deposit an administrative penalty imposed under this section into the General Fund.

(3) For a person subject to an uncontested citation, a stipulated settlement, or a finding of a violation in an adjudicative proceeding under this section, the department may:

(a) for a fine amount not already specified in law, assess the person a fine of up to $5,000 per violation, in accordance with a fine schedule that the department establishes by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; or

(b) order the person to cease and desist from the action that creates a violation.

(4) The department may not revoke a medical cannabis pharmacy's license without first directing the medical cannabis pharmacy to appear before an adjudicative proceeding conducted under Title 63G, Chapter 4, Administrative Procedures Act.

(5) If, within 20 calendar days after the day on which the department issues a citation for a violation of this chapter, the person that is the subject of the citation fails to request a hearing to contest the citation, the citation becomes the department's final order.
(6) The department may, for a person who fails to comply with a citation under this section:
(a) refuse to issue or renew the person's license agent registration card; or
(b) suspend, revoke, or place on probation the person's license or agent registration card.
(7)
(a) Except where a criminal penalty is expressly provided for a specific violation of this chapter, if an individual violates a provision of this chapter, the individual is:
(i) guilty of an infraction; and
(ii) subject to a $100 fine.
(b) An individual who is guilty of a violation described in Subsection (7)(a) is not guilty of a violation of Title 58, Chapter 37, Utah Controlled Substances Act, for the conduct underlying the violation described in Subsection (7)(a).

Renumbered and Amended by Chapter 1, 2018 Special Session 3

26-61a-703 Report.
(1) By the November interim meeting each year, the department shall report to the Health and Human Services Interim Committee on:
(a) the number of applications and renewal applications filed for medical cannabis cards;
(b) the number of qualifying patients and designated caregivers;
(c) the nature of the debilitating medical conditions of the qualifying patients;
(d) the age and county of residence of cardholders;
(e) the number of medical cannabis cards revoked;
(f) the number of practitioners providing recommendations for qualifying patients;
(g) the number of license applications and renewal license applications received;
(h) the number of licenses the department has issued in each county;
(i) the number of licenses the department has revoked;
(j) the quantity and timeliness of state central fill shipments, including the amount of time between recommendation to the state central fill medical cannabis pharmacy and arrival of a state central fill shipment at a local health department;
(k) the market share of state central fill shipments;
(l) the expenses incurred and revenues generated from the medical cannabis program;
(m) the expenses incurred and revenues generated from the state central fill medical cannabis pharmacy, including a profit and loss statement; and
(n) an analysis of product availability, including the price differential between comparable products, in medical cannabis pharmacies and the state central fill medical cannabis pharmacy.
(2) The department may not include personally identifying information in the report described in this section.

Renumbered and Amended by Chapter 1, 2018 Special Session 3

Chapter 62

Tobacco Retail Permit

Part 1
General Provisions

26-62-101 Title.

This chapter is known as "Tobacco Retail Permit."

Enacted by Chapter 231, 2018 General Session

26-62-102 Definitions.

As used in this chapter:

(1) "Community location" means the same as that term is defined:
  (a) as it relates to a municipality, in Section 10-8-41.6; and
  (b) as it relates to a county, in Section 17-50-333.
(2) "Employee" means an employee of a tobacco retailer.
(3) "Enforcing agency" means the state Department of Health, or any local health department enforcing the provisions of this chapter.
(4) "General tobacco retailer" means a tobacco retailer that is not a retail tobacco specialty business.
(5) "Local health department" means the same as that term is defined in Section 26A-1-102.
(6) "Permit" means a tobacco retail permit issued under this chapter.
(7) "Retail tobacco specialty business" means the same as that term is defined:
  (a) as it relates to a municipality, in Section 10-8-41.6; and
  (b) as it relates to a county, in Section 17-50-333.
(8) "Tax commission license" means a license issued by the State Tax Commission under:
  (a) Section 59-14-201 to sell cigarettes at retail;
  (b) Section 59-14-301 to sell tobacco products at retail; or
  (c) Section 59-14-803 to sell an electronic cigarette product.
(9) "Tobacco product" means:
  (a) a cigar, cigarette, or electronic cigarette as those terms are defined in Section 76-10-101;
  (b) a tobacco product as that term is defined in Section 59-14-102, including:
    (i) chewing tobacco; or
    (ii) any substitute for a tobacco product, including flavoring or additives to tobacco; or
  (c) tobacco paraphernalia as that term is defined in Section 76-10-104.1.
(10) "Tobacco retailer" means a person that is required to obtain a tax commission license.

Renumbered and Amended by Chapter 231, 2018 General Session

26-62-103 Regulation of tobacco retailers.

The regulation of a tobacco retailer is an exercise of the police powers of the state, and through delegation, to other governmental entities.

Enacted by Chapter 231, 2018 General Session

Part 2

Permit Requirements

26-62-201 Permitting requirement.

(1)
  (a) Beginning July 1, 2018, a tobacco retailer shall hold a valid tobacco retail permit issued in accordance with this chapter by the local health department with jurisdiction over the physical location where the tobacco retailer operates.
  (b) A tobacco retailer without a valid permit may not:
    (i) place tobacco products in public view;
    (ii) display any advertisement related to tobacco products that promotes the sale, distribution, or use of those products; or
    (iii) sell, offer for sale, or offer to exchange for any form of consideration, tobacco or tobacco products.
(2) A local health department may issue a permit under this chapter for a tobacco retailer in the classification of:
  (a) a general tobacco retailer; or
  (b) a retail tobacco specialty business.
(3) A permit under this chapter is:
  (a) valid only for one physical location, including a vending machine;
  (b) valid only at one fixed business address; and
  (c) if multiple tobacco retailers are at the same address, separately required for each tobacco retailer.
(4) Notwithstanding the requirement in Subsection (1), a person that holds a tax commission license that was valid on July 1, 2018:
  (a) may operate without a permit under this chapter until December 31, 2018; and
  (b) shall obtain a permit from a local health department under this chapter before January 1, 2019.

Enacted by Chapter 231, 2018 General Session

26-62-202 Permit application.

(1) A local health department shall issue a permit under this chapter for a tobacco retailer if the local health department determines that the applicant:
  (a) accurately provided all information required under Subsection (3) and, if applicable, Subsection (4); and
  (b) meets all requirements for a permit under this chapter.
(2) An applicant for a permit shall:
  (a) submit an application described in Subsection (3) to the local health department with jurisdiction over the area where the tobacco retailer is located; and
  (b) pay all applicable fees described in Section 26-62-203.
(3) The application for a permit shall include:
  (a) the name, address, and telephone number of each proprietor;
  (b) the name and mailing address of each proprietor authorized to receive permit-related communication and notices;
  (c) the business name, address, and telephone number of the single, fixed location for which a permit is sought;
  (d) evidence that the location for which a permit is sought has a valid tax commission license;

(e) information regarding whether, in the past 24 months, any proprietor of the tobacco retailer has been determined to have violated, or has been a proprietor at a location that has been determined to have violated:
(i) a provision of this chapter;
(ii)Chapter 38, Utah Indoor Clean Air Act;
(iii)Title 76, Chapter 10, Part 1, Cigarettes and Tobacco and Psychotoxic Chemical Solvents;
(iv)Title 76, Chapter 10, Part 16, Pattern of Unlawful Activity Act;
(v) regulations restricting the sale and distribution of cigarettes and smokeless tobacco issued by the United States Food and Drug Administration, 21 C.F.R. Part 1140; or
(vi) any other provision of state law or local ordinance regarding the sale, marketing, or distribution of tobacco products; and
(f) the dates of all violations disclosed under this Subsection (3).
(4)
(a) In addition to the information described in Subsection (3), an applicant for a retail tobacco specialty business permit shall include evidence showing whether the business is located within:
(i) 1,000 feet of a community location;
(ii) 600 feet of another retail tobacco specialty business; or
(iii) 600 feet of property used or zoned for agricultural or residential use.
(b) For purposes of Subsection (4)(a), the proximity requirements shall be measured in a straight line from the nearest entrance of the retail tobacco specialty business to the nearest property boundary of a location described in Subsections (4)(a)(i) through (iii), without regard to intervening structures or zoning districts.
(5) The department or a local health department may not deny a permit to a retail tobacco specialty business under Subsection (4) if the retail tobacco specialty business obtained a license to operate the retail tobacco specialty business before December 31, 2015, from:
(a) a municipality under Section 10-8-41.6; or
(b) a county under Section 17-50-333.
(6)
(a) The department shall establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, a permit process for local health departments in accordance with this chapter.
(b) The permit process established by the department under Subsection (6)(a) may not require any information in an application that is not required by this section.

Amended by Chapter 157, 2019 General Session

26-62-203 Permit term and fees.
(1)
(a) The term of a permit issued under this chapter to a retail tobacco specialty business is one year.
(b) The term of a permit issued under this chapter to a general tobacco retailer is two years.
(2)
(a) A local health department may not issue a permit under this chapter until the applicant has paid a permit fee to the local health department of:
(i) $30 for a new permit;
(ii) $20 for a permit renewal; or
(iii) $30 for reinstatement of a permit that has been revoked, suspended, or allowed to expire.

(b) A local health department that collects fees under Subsection (2)(a) shall use the fees to administer the permit requirements under this chapter.
(c) In addition to the fee described in Subsection (2)(a), a local health department may establish and collect a fee to perform a plan review for a retail tobacco specialty business permit.
(3) A permit holder may apply for a renewal of a permit no earlier than 30 days before the day on which the permit expires.
(4) A tobacco retailer that fails to renew a permit before the permit expires may apply to reinstate the permit by submitting to the local health department:
(a) the information required in Subsection 26-62-202(3) and, if applicable, Subsection 26-62-202(4);
(b) the fee for the reinstatement of a permit; and
(c) a signed affidavit affirming that the tobacco retailer has not violated the prohibitions in Subsection 26-62-201(1)(b) after the permit expired.

Enacted by Chapter 231, 2018 General Session

26-62-204 Permit nontransferable.
(1) A permit is nontransferable.
(2) If the information described in Subsection 26-62-202(3) changes, a tobacco retailer:
(a) may not renew the permit; and
(b) shall apply for a new permit no later than 15 days after the information in Subsection 26-62-202(3) changes.

Enacted by Chapter 231, 2018 General Session

Superseded 7/1/2020
26-62-205 Permit requirements for a retail tobacco specialty business.
A retail tobacco specialty business shall:
(1) except as provided in Subsection 76-10-105.1(4), prohibit any individual under 19 years of age from entering the business; and
(2) prominently display at the retail tobacco specialty business a sign on the public entrance of the business that communicates the prohibition in Subsection 76-10-105.1(4).

Enacted by Chapter 231, 2018 General Session

Effective 7/1/2020
26-62-205 Permit requirements for a retail tobacco specialty business.
A retail tobacco specialty business shall:
(1) except as provided in Subsection 76-10-105.1(4), prohibit any individual from entering the business if the individual is:
(a) beginning July 1, 2020, and ending June 30, 2021, under 20 years old; and
(b) beginning July 1, 2021, under 21 years old; and
(2) prominently display at the retail tobacco specialty business a sign on the public entrance of the business that communicates the prohibition in Subsection 76-10-105.1(4).

Amended by Chapter 232, 2019 General Session

Part 3
Enforcement

26-62-301 Permit violation.

A person is in violation of the permit issued under this chapter if the person violates:

(1) a provision of this chapter;
(2) a provision of licensing laws under Section 10-8-41.6 or Section 17-50-333;
(3) a provision of Title 76, Chapter 10, Part 1, Cigarettes and Tobacco and Psychotoxic Chemical Solvents;
(4) a provision of Title 76, Chapter 10, Part 16, Pattern of Unlawful Activity Act;
(5) a regulation restricting the sale and distribution of cigarettes and smokeless tobacco issued by the United States Food and Drug Administration under 21 C.F.R. Part 1140; or
(6) any other provision of state law or local ordinance regarding the sale, marketing, or distribution of tobacco products.

Enacted by Chapter 231, 2018 General Session

26-62-302 Enforcement by state and local health departments.

The department and local health departments shall enforce this chapter under the procedures of Title 63G, Chapter 4, Administrative Procedures Act, as an informal adjudicative proceeding, including:

(1) notifying a tobacco retailer of alleged violations of this chapter;
(2) conducting hearings;
(3) determining violations of this chapter; and
(4) imposing civil administrative penalties.

Renumbered and Amended by Chapter 231, 2018 General Session

26-62-303 Inspection of retail tobacco businesses.

The department or a local health department may inspect a tobacco retailer to determine whether the tobacco retailer:

(1) continues to meet the qualifications for the permit issued under this chapter;
(2) if applicable, continues to meet the requirements for a retail tobacco specialty business license issued under Section 10-8-41.6 or Section 17-50-333;
(3) engaged in a pattern of unlawful activity under Title 76, Chapter 10, Part 16, Pattern of Unlawful Activity Act;
(4) violated any of the regulations restricting the sale and distribution of cigarettes and smokeless tobacco issued by the United States Food and Drug Administration under 21 C.F.R. Part 1140; or
(5) has violated any other provision of state law or local ordinance.

Enacted by Chapter 231, 2018 General Session

Superseded 7/1/2020

26-62-304 Hearing -- Evidence of criminal conviction.

(1) At a civil hearing conducted under Section 26-62-302, evidence of the final criminal conviction of a tobacco retailer or employee for violation of Section 76-10-104 at the same location and

within the same time period as the location and time period alleged in the civil hearing for violation of this chapter for sale of tobacco products to a person under the age of 19 is prima facie evidence of a violation of this chapter.

(2) If the tobacco retailer is convicted of violating Section 76-10-104, the enforcing agency:

(a) may not assess an additional monetary penalty under this chapter for the same offense for which the conviction was obtained; and

(b) may revoke or suspend a permit in accordance with Section 26-62-305.

Renumbered and Amended by Chapter 231, 2018 General Session

Effective 7/1/2020

26-62-304 Hearing -- Evidence of criminal conviction.

(1) At a civil hearing conducted under Section 26-62-302, evidence of the final criminal conviction of a tobacco retailer or employee for violation of Section 76-10-104 at the same location and within the same time period as the location and time period alleged in the civil hearing for violation of this chapter for sale of tobacco products to an individual under the following ages is prima facie evidence of a violation of this chapter:

(a) beginning July 1, 2020, and ending June 30, 2021, under 20 years old; and

(b) beginning July 1, 2021, under 21 years old.

(2) If the tobacco retailer is convicted of violating Section 76-10-104, the enforcing agency:

(a) may not assess an additional monetary penalty under this chapter for the same offense for which the conviction was obtained; and

(b) may revoke or suspend a permit in accordance with Section 26-62-305.

Amended by Chapter 232, 2019 General Session

Superseded 7/1/2020

26-62-305 Penalties.

(1)

(a) If, following an inspection by an enforcing agency, or an investigation or issuance of a citation or information under Section 77-39-101, an enforcing agency determines that a person has violated the terms of a permit issued under this chapter, the enforcing agency may impose the penalties described in this section.

(b) If multiple violations are found in a single inspection or investigation, only one violation shall count toward the penalties described in this section.

(2)

(a) The administrative penalty for a first violation at a retail location is a penalty of not more than $500.

(b) The administrative penalty for a second violation at the same retail location that occurs within one year of a previous violation is a penalty of not more than $750.

(c) The administrative penalty for a third or subsequent violation at the same retail location that occurs within two years after two or more previous violations is:

(i) a suspension of the retail tobacco business permit for 30 consecutive business days within 60 days after the day on which the third or subsequent violation occurs; or

(ii) a penalty of not more than $1,000.

(3) The department or a local health department may:

(a) revoke a permit if a fourth violation occurs within two years of three previous violations;

(b) in addition to a monetary penalty imposed under Subsection (2), suspend the permit if the violation is due to a sale of tobacco products to a person under 19 years of age; and
(c) if applicable, recommend to a municipality or county that a retail tobacco specialty business license issued under Section 10-8-41.6 or 17-50-333 be suspended or revoked.
(4)
(a) Except when a transfer described in Subsection (5) occurs, a local health department may not issue a permit to:
(i) a tobacco retailer for whom a permit is suspended or revoked under Subsection (3); or
(ii) a tobacco retailer that has the same proprietor, director, corporate officer, partner, or other holder of significant interest as another tobacco retailer for whom a permit is suspended or revoked under Subsection (3).
(b) A person whose permit:
(i) is suspended under this section may not apply for a new permit for any other tobacco retailer for a period of 12 months after the day on which an enforcing agency suspends the permit; and
(ii) is revoked may not apply for a new permit for any tobacco retailer for a period of 24 months after the day on which an enforcing agency revokes the permit.
(5) Violations of this chapter, Section 10-8-41.6, or Section 17-50-333 that occur at a tobacco retailer location shall stay on the record for that tobacco retailer location unless:
(a) the tobacco retailer is transferred to a new proprietor; and
(b) the new proprietor provides documentation to the local health department that the new proprietor is acquiring the tobacco retailer in an arm's length transaction from the previous proprietor.

Renumbered and Amended by Chapter 231, 2018 General Session

Effective 7/1/2020
26-62-305 Penalties.
(1)
(a) If, following an inspection by an enforcing agency, or an investigation or issuance of a citation or information under Section 77-39-101, an enforcing agency determines that a person has violated the terms of a permit issued under this chapter, the enforcing agency may impose the penalties described in this section.
(b) If multiple violations are found in a single inspection or investigation, only one violation shall count toward the penalties described in this section.
(2)
(a) The administrative penalty for a first violation at a retail location is a penalty of not more than $500.
(b) The administrative penalty for a second violation at the same retail location that occurs within one year of a previous violation is a penalty of not more than $750.
(c) The administrative penalty for a third or subsequent violation at the same retail location that occurs within two years after two or more previous violations is:
(i) a suspension of the retail tobacco business permit for 30 consecutive business days within 60 days after the day on which the third or subsequent violation occurs; or
(ii) a penalty of not more than $1,000.
(3) The department or a local health department may:
(a) revoke a permit if a fourth violation occurs within two years of three previous violations;

(b) in addition to a monetary penalty imposed under Subsection (2), suspend the permit if the violation is due to a sale of tobacco products to an individual under:
(i) beginning July 1, 2020, and ending June 30, 2021, 20 years old; and
(ii) beginning July 1, 2021, 21 years old; and
(c) if applicable, recommend to a municipality or county that a retail tobacco specialty business license issued under Section 10-8-41.6 or 17-50-333 be suspended or revoked.

(4)
(a) Except when a transfer described in Subsection (5) occurs, a local health department may not issue a permit to:
(i) a tobacco retailer for whom a permit is suspended or revoked under Subsection (3); or
(ii) a tobacco retailer that has the same proprietor, director, corporate officer, partner, or other holder of significant interest as another tobacco retailer for whom a permit is suspended or revoked under Subsection (3).
(b) A person whose permit:
(i) is suspended under this section may not apply for a new permit for any other tobacco retailer for a period of 12 months after the day on which an enforcing agency suspends the permit; and
(ii) is revoked may not apply for a new permit for any tobacco retailer for a period of 24 months after the day on which an enforcing agency revokes the permit.

(5) Violations of this chapter, Section 10-8-41.6, or Section 17-50-333 that occur at a tobacco retailer location shall stay on the record for that tobacco retailer location unless:
(a) the tobacco retailer is transferred to a new proprietor; and
(b) the new proprietor provides documentation to the local health department that the new proprietor is acquiring the tobacco retailer in an arm's length transaction from the previous proprietor.

Amended by Chapter 232, 2019 General Session

26-62-306 Recognition of tobacco retailer training program.

(1) In determining the amount of the monetary penalty to be imposed for an employee's violation of this chapter, a hearing officer shall reduce the civil penalty by at least 50% if the hearing officer determines that:
(a) the tobacco retailer has implemented a documented employee training program; and
(b) the employees have completed that training program within 30 days after the day on which each employee commences the duties of selling tobacco products.

(2)
(a) For the first offense at a location, if the hearing officer determines under Subsection (1) that the tobacco retailer licensee has not implemented a documented training program with a written curriculum for employees at that location regarding compliance with this chapter, the hearing officer may suspend all or a portion of the penalty if:
(i) the tobacco retailer agrees to initiate a training program for employees at that location; and
(ii) the training program begins within 30 days after the hearing officer makes a determination under this Subsection (2)(a).
(b) If the hearing officer determines at a subsequent hearing that the tobacco retailer has not implemented the training program within the time period required under Subsection (2)(a)(ii), the hearing officer shall promptly impose the suspended monetary penalty, unless the tobacco retailer demonstrates good cause for an extension of time for implementation of the training program.

Renumbered and Amended by Chapter 231, 2018 General Session

26-62-307 Allocation of civil penalties.

Civil monetary penalties collected under this chapter shall be allocated as follows:

(1) if a local health department conducts an adjudicative proceeding under Section 26-62-302, the penalty shall be paid to the treasurer of the county in which the violation was committed, and transferred to the local health department; and

(2) if the department conducts a civil hearing under Section 26-62-302, the penalty shall be deposited in the state's General Fund, and may be appropriated by the Legislature to the department for use in enforcement of this chapter.

Renumbered and Amended by Chapter 231, 2018 General Session

Chapter 63
Nurse Home Visiting Pay-for-success Program

Part 1
General Provisions

26-63-101 Title.

This chapter is known as the "Nurse Home Visiting Pay-for-Success Program."

Enacted by Chapter 430, 2018 General Session

26-63-102 Definitions.

As used in this chapter:

(1) "At-risk individual" means an individual who qualifies for coverage under:
  (a) the Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act;
  (b) the Medicaid program, as defined in Section 26-18-2;
  (c) the Special Supplemental Nutrition Program for Women, Infants, and Children, established in 42 U.S.C. Sec. 1786; or
  (d) Temporary Assistance for Needy Families, described in 42 U.S.C. Sec. 601 et seq.

(2) "Eligible participant" means an individual who:
  (a) is referred to the program as an at-risk individual; and
  (b) is appropriate for participation in the program as determined by a service provider.

(3) "Fiscal intermediary entity" means an organization that has the necessary experience to coordinate the funding and management of a pay-for-success contract.

(4) "Independent evaluator" means a person that is contracted to conduct an annual evaluation of the performance outcome measures specified in the pay-for-success contract.

(5) "Investor" means a private person that:
  (a) provides an up-front cash payment to fund the program; and
  (b) receives a success payment if the performance outcome measures are satisfied.

(6) "Pay-for-success contract" means a contract entered into by the department in accordance with Section 26-63-301.
(7) "Performance outcome measure" means a measurable outcome established by the department under Section 26-63-302.
(8) "Program" means the Nurse Home Visiting Pay-for-Success Program created in Section 26-63-201.
(9) "Programmatic intermediary entity" means a private, not-for-profit organization that enters into a pay-for-success contract with the department to operate the program.
(10) "Qualified nurse" means an individual who is licensed to practice as a registered nurse in the state.
(11) "Restricted account" means the Nurse Home Visiting Restricted Account created in Section 26-63-601.
(12) "Service provider" means a person that receives a contract from the programmatic intermediary entity to provide the services described in Section 26-63-203.
(13) "Success payment" means the amount paid by the department to an investor from the restricted account in accordance with the terms of a pay-for-success contract.

Amended by Chapter 136, 2019 General Session

Part 2
Nurse Home Visiting Pay-for-success Program

26-63-201 Creation.

There is created the Nurse Home Visiting Pay-for-Success Program in the department.

Enacted by Chapter 430, 2018 General Session

26-63-202 Department duties.

The department shall:
(1) administer the pilot program described in Section 26-63-401;
(2) negotiate and enter into:
(a) a pay-for-success contract to provide the services described in Section 26-63-203; and
(b) a contract with an independent evaluator to perform the evaluation described in Section 26-63-303;
(3) provide necessary data to the independent evaluator to facilitate assessment of the performance outcome metrics;
(4) if the independent evaluator determines that the specified performance outcome measures have been achieved, make a success payment to the investors in the amount specified in the pay-for-success contract;
(5) refer pregnant at-risk individuals who are likely to be first-time mothers to the program for potential enrollment; and
(6) calculate the potential savings to the state through a Medicaid waiver or a state plan amendment under Section 26-63-502.

Enacted by Chapter 430, 2018 General Session

26-63-203 Nurse home visiting program.

(1) A participant in a program shall receive ongoing in-person home visits from a qualified nurse from early in the participant's pregnancy to up to two years after the participant's child is born.

(2)

(a) To participate in the program, an individual must be an eligible participant at the time of enrollment.

(b) The program shall prioritize the enrollment of first-time mothers, as defined by the programmatic intermediary entity.

(c) The programmatic intermediary entity may request a limited waiver from the requirement in Subsection (2)(a) from the department if the programmatic intermediary entity can demonstrate that a group:

(i) is significantly underserved; and

(ii) meets all other requirements of the program.

(3) The services provided during a home visit described in Subsection (1) shall be provided according to a set of standards that:

(a) are nationally recognized;

(b) are evidence-based, with support from at least two reliable, randomized control trials with statistically significant results; and

(c) have demonstrated sizable and sustained results.

Enacted by Chapter 430, 2018 General Session

26-63-204 Service providers.

(1) The programmatic intermediary entity may contract with one or more qualified service providers to provide the services described in Section 26-63-203 for the program.

(2) A service provider that receives a contract under Subsection (1) shall:

(a) have a demonstrated record of providing social services to low-income populations;

(b) agree to deliver services according to the standards set by the programmatic intermediary entity; and

(c) submit data to the independent evaluator that are necessary to evaluate the performance outcome measures.

(3) The programmatic intermediary entity shall seek approval from the department before entering into a contract with a service provider under this section.

(4) The selection of a service provider by the programmatic intermediary entity:

(a) shall be conducted with input from the department; and

(b) shall be conducted in accordance with a rigorous, evidence-based selection process.

Enacted by Chapter 430, 2018 General Session

Part 3
Pay-for-success Contract

26-63-301 Pay-for-success contract -- Success payments -- Outcome measures.

The department shall implement a program under this chapter through a pay-for-success contract, which:

(1) shall include at least all of the following as parties to the contract:

(a) the department;
(b) an independent evaluator;
(c) a programmatic intermediary entity; and
(d) an investor;
(2) shall include clear performance outcome measures that trigger a success payment;
(3) shall establish a payment schedule for investors if the performance outcome measures are achieved;
(4) shall only allow repayment with funds appropriated from the restricted account;
(5) shall prohibit civil action by investors against the state if a success payment is not made because performance outcome measures are not achieved; and
(6) may not, under any circumstance, cause the total outstanding obligations under this chapter to exceed $25,000,000.

Amended by Chapter 136, 2019 General Session

26-63-302 Performance outcome measures.
(1) The department shall establish performance outcome measures that shall be used to determine the conditions of a success payment under a contract described in Section 26-63-301.
(2)
(a) Before entering into a pay-for-success contract under this chapter, the department shall report the terms of the proposed pay-for-success contract, including the proposed outcome measures, to the Executive Appropriations Committee.
(b) The report described in Subsection (2)(a) shall include, at a minimum, the following items:
(i) the populations selected as targetable and high-need populations, including the department's assessment of whether similar publicly funded services are available to those populations;
(ii) the benchmarks selected to measure each performance outcome measure;
(iii) the targets selected for each performance outcome measure; and
(iv) the amount that will be paid to each party in the pay-for-success contract if a target is reached.
(c) The department may not enter into a pay-for-success contract under this chapter until after the department makes the report described in Subsection (2)(a) to the Executive Appropriations Committee.
(3) The performance outcome measures described in Subsection (2) shall include, at a minimum, the following categories:
(a) preterm births;
(b) child injury;
(c) child immunization rates through age two;
(d) screening for postpartum depression; and
(e) enrollment targets for the program.
(4) The program outcome measures shall be determined using data from:
(a) the pilot phase described in Section 26-63-401;
(b) peer-reviewed studies; or
(c) any government entity.
(5) The enrollment targets described in Subsection (3)(e) shall include a measure of:
(a) the number of participants in the program; and
(b) the proportion of participants who come from a zip code in which 15% or more of households have incomes below the federal poverty guidelines established by the secretary of the United States Department of Health and Human Services.

Enacted by Chapter 430, 2018 General Session

26-63-303 Independent evaluator.

(1) The department shall contract with an independent evaluator who will perform an assessment for the pay-for-success contract.

(2) The independent evaluator shall:

(a) have demonstrated expertise in evaluating home visiting programs; and

(b) have successfully completed at least two independent evaluations of a program that utilizes the pay-for-success contract model before entering into the contract.

Enacted by Chapter 430, 2018 General Session

Part 4
Implementation

26-63-401 Pilot phase.

(1) Before July 1, 2019, the department shall:

(a) identify whether there is a targetable, high-need population for the implementation of the home visiting program;

(b) identify service providers that are able to reach the targeted population with the program; and

(c) gather data needed to make the evaluation in Subsection (3).

(2) The department may:

(a) contract with a third party with the necessary expertise to act as a programmatic intermediary entity to administer the pilot phase described in Subsection (1);

(b) contract with a fiscal intermediary entity to administer the pilot phase described in Subsection (1); and

(c) execute a single contract with the programmatic intermediary entity to administer the pilot phase described in this section and the implementation phase described in Section 26-63-402.

(3) The department shall begin the implementation phase described in Section 26-63-203 if the department determines that:

(a) there is at least one identifiable high-need population that would benefit from the program;

(b) there are sufficient service providers to provide services under the program to the population described in Subsection (3)(a);

(c) there is evidence that the program would produce positive outcomes for the state; and

(d) there are persons that are qualified and have expressed an interest in serving as:

(i) a programmatic intermediary entity;

(ii) an independent evaluator; and

(iii) an investor.

Amended by Chapter 136, 2019 General Session

26-63-402 Implementation phase.

(1) If all of the conditions described in Subsection 26-63-401(3) are satisfied, and after the department has made the report described in Subsection 26-63-302(2), the department shall

enter into a pay-for-success contract with a programmatic intermediary entity, an independent evaluator, and investors to provide the services required under Section 26-63-203.
(2) The department shall make success payments from the restricted account to investors in accordance with the terms of the pay-for-success contract.
(3) The program shall operate for six years.

Amended by Chapter 136, 2019 General Session

26-63-403 Study and expansion phase.

Before July 1, 2025, the department shall create a report to the Legislature describing:
(1) cost savings and other benefits to the state resulting from the program; and
(2) options for:
(a) increasing the number of individuals served by home visiting programs;
(b) improving the effectiveness of home visiting programs funded by the state;
(c) leveraging private and government funding, including Medicaid funding, to increase the use and effectiveness of home visiting programs in the state;
(d) coordinating the identification of individuals who could benefit from home visiting programs;
(e) coordinating the delivery of services provided through multiple home visiting programs, where appropriate; and
(f) funding home visiting programs if funding through the federal government's Maternal, Infant, and Early Childhood Home Visiting program is eliminated or reduced.

Enacted by Chapter 430, 2018 General Session

Part 5
Miscellaneous Provisions

26-63-501 Reporting requirement.

The department shall report to the Health and Human Services Interim Committee, before October 1 of each year while the program is in operation, regarding:
(1) the number of participants enrolled in the program;
(2) the amount of any success payments that have been made;
(3) an estimate of savings to the state resulting from this program; and
(4) suggestions for legislation that would make a home visiting program or a pay-for-success contract more efficient or widely available throughout the state.

Enacted by Chapter 430, 2018 General Session

26-63-502 Medicaid waiver.

(1) The department may submit a Medicaid waiver to the secretary of the United States Department of Health and Human Services to expand the Nurse Home Visiting Pay-for-Success Program.
(2) The department shall report to the Health and Human Services Interim Committee or the Health and Human Services Standing Committee within 60 days after the date on which the department submits a waiver request under Subsection (1).

Enacted by Chapter 430, 2018 General Session

26-63-503 Limited liability.

(1) An investor may not take any action against the state, a political subdivision, a programmatic intermediary entity, a service provider, or a financial intermediary entity for:
  (a) the failure of a success payment due to the failure to achieve the performance outcome measures; or
  (b) any amount over the $25,000,000 limit for all success payments in the aggregate for the program.
(2) The limitation described in Subsection (1) does not prohibit an investor from taking action against the state for a failure to make a success payment in accordance with the pay-for-success contract if the performance outcome measures are achieved and the limit has not been exceeded.

Enacted by Chapter 430, 2018 General Session

26-63-504 Repeal date.

This chapter is repealed on July 1, 2026, in accordance with Section 63I-1-226.

Enacted by Chapter 430, 2018 General Session

Part 6
Nurse Home Visiting Restricted Account

26-63-601 Nurse Home Visiting Restricted Account.

(1) There is created a restricted account within the General Fund known as the "Nurse Home Visiting Restricted Account."
(2) The restricted account consists of:
  (a) money appropriated to the restricted account by the Legislature;
  (b) private donations; and
  (c) all income and interest derived from the deposit and investment of money in the account.
(3) Subject to legislative appropriations, money in the restricted account may be used to fund activities related to the program created in this chapter.

Renumbered and Amended by Chapter 430, 2018 General Session

Chapter 64
Family Planning Access Act

26-64-101 Title.

This chapter is known as the "Family Planning Access Act."

Enacted by Chapter 295, 2018 General Session

26-64-102 Definitions.

As used in this chapter:

(1) "Dispense" means the same as that term is defined in Section 58-17b-102.

(2) "Division" means the Division of Occupational and Professional Licensing created in Section 58-1-103.

(3) "Local health department" means:

(a) a local health department, as defined in Section 26A-1-102; or

(b) a multicounty local health department, as defined in Section 26A-1-102.

(4) "Patient counseling" means the same as that term is defined in Section 58-17b-102.

(5) "Pharmacist" means the same as that term is defined in Section 58-17b-102.

(6) "Pharmacy intern" means the same as that term is defined in Section 58-17b-102.

(7) "Physician" means the same as that term is defined in Section 58-67-102.

(8) "Prescribe" means the same as that term is defined in Section 58-17b-102.

(9)

(a) "Self-administered hormonal contraceptive" means a self-administered hormonal contraceptive that is approved by the United States Food and Drug Administration to prevent pregnancy.

(b) "Self-administered hormonal contraceptive" includes an oral hormonal contraceptive, a hormonal vaginal ring, and a hormonal contraceptive patch.

(c) "Self-administered hormonal contraceptive" does not include any drug intended to induce an abortion, as that term is defined in Section 76-7-301.

Enacted by Chapter 295, 2018 General Session

26-64-103 Voluntary participation.

This chapter does not create a duty or standard of care for a person to prescribe or dispense a self-administered hormonal contraceptive.

Enacted by Chapter 295, 2018 General Session

26-64-104 Authorization to dispense self-administered hormonal contraceptives.

Notwithstanding Title 58, Chapter 17b, Pharmacy Practice Act, a person licensed under Title 58, Chapter 17b, Pharmacy Practice Act, to dispense a self-administered hormonal contraceptive may dispense the self-administered hormonal contraceptive:

(1) to a patient who is 18 years old or older;

(2) pursuant to a standing prescription drug order made in accordance with Section 26-64-105;

(3) without any other prescription drug order from a person licensed to prescribe a self-administered hormonal contraceptive; and

(4) in accordance with the dispensing guidelines in Section 26-64-106.

Enacted by Chapter 295, 2018 General Session

26-64-105 Standing prescription drug orders for a self-administered hormonal contraceptive.

A physician who is licensed to prescribe a self-administered hormonal contraceptive, including a physician acting in the physician's capacity as an employee of the department, or a medical director of a local health department, may issue a standing prescription drug order authorizing

the dispensing of the self-administered hormonal contraceptive under Section 26-64-104 in accordance with a protocol that:
(1) requires the physician to specify the persons, by professional license number, authorized to dispense the self-administered hormonal contraceptive;
(2) requires the physician to review at least annually the dispensing practices of those authorized by the physician to dispense the self-administered hormonal contraceptive;
(3) requires those authorized by the physician to dispense the self-administered hormonal contraceptive to make and retain a record of each person to whom the self-administered hormonal contraceptive is dispensed, including:
  (a) the name of the person;
  (b) the drug dispensed; and
  (c) other relevant information; and
(4) is approved by the department by administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Enacted by Chapter 295, 2018 General Session

26-64-106 Guidelines for dispensing a self-administered hormonal contraceptive.
(1) A pharmacist or pharmacist intern who dispenses a self-administered hormonal contraceptive under this chapter:
  (a) shall obtain a completed self-screening risk assessment questionnaire, that has been approved by the division in collaboration with the Board of Pharmacy and the Physicians Licensing Board, from the patient before dispensing the self-administered hormonal contraceptive;
  (b) if the results of the evaluation in Subsection (1)(a) indicate that it is unsafe to dispense a self-administered hormonal contraceptive to a patient:
    (i) may not dispense a self-administered hormonal contraceptive to the patient; and
    (ii) shall refer the patient to a primary care or women's health care practitioner;
  (c) may not continue to dispense a self-administered hormonal contraceptive to a patient for more than 24 months after the date of the initial prescription without evidence that the patient has consulted with a primary care or women's health care practitioner during the preceding 24 months; and
  (d) shall provide the patient with:
    (i) written information regarding:
      (A) the importance of seeing the patient's primary care practitioner or women's health care practitioner to obtain recommended tests and screening; and
      (B) the effectiveness and availability of long-acting reversible contraceptives as an alternative to self-administered hormonal contraceptives; and
    (ii) a copy of the record of the encounter with the patient that includes:
      (A) the patient's completed self-assessment tool; and
      (B) a description of the contraceptives dispensed, or the basis for not dispensing a contraceptive.
(2) If a pharmacist dispenses a self-administered hormonal contraceptive to a patient, the pharmacist shall, at a minimum, provide patient counseling to the patient regarding:
  (a) the appropriate administration and storage of the self-administered hormonal contraceptive;
  (b) potential side effects and risks of the self-administered hormonal contraceptive;
  (c) the need for backup contraception;
  (d) when to seek emergency medical attention; and

(e) the risk of contracting a sexually transmitted infection or disease, and ways to reduce the risk of contraction.

(3) The division, in collaboration with the Board of Pharmacy and the Physicians Licensing Board, shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, establishing the self-screening risk assessment questionnaire described in Subsection (1)(a).

Enacted by Chapter 295, 2018 General Session

26-64-107 Limited civil liability.

A physician who issues a standing prescription drug order in accordance with Section 26-64-105 is not liable for any civil damages for acts or omissions resulting from the dispensing of a self-administered hormonal contraceptive under this chapter.

Enacted by Chapter 295, 2018 General Session

Effective 7/1/2019

Chapter 65
Cannabidiol Product Act

Effective 7/1/2019

Part 1
General Provisions

Effective 7/1/2019

26-65-101 Title.

This chapter is known as the "Cannabidiol Product Act."

Enacted by Chapter 452, 2018 General Session

Effective 7/1/2019

26-65-102 Definitions.

(1) "Agent" means an employee or independent contractor of an entity.

(2) "Cannabidiol product" means a chemical compound extracted from cannabis that:

(a) is processed into a medicinal dosage form; and

(b) contains less than 0.3% tetrahydrocannabinol by dry weight.

(3) "Cannabis" means marijuana, as that term is defined in Section 58-37-2.

(4) "Medicinal dosage form" means a qualifying dosage form for a cannabidiol product under Section 26-65-103.

(5) "Physician" means an individual who is licensed to practice:

(a) medicine, under Title 58, Chapter 67, Utah Medical Practice Act; or

(b) osteopathic medicine, under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

Amended by Chapter 1, 2018 Special Session 3

Effective 7/1/2019

26-65-103 Medicinal dosage form.

(1) For the purpose of this chapter, any of the following is a qualifying medicinal dosage form for a cannabidiol product:
  (a) a tablet;
  (b) a capsule;
  (c) a concentrated oil;
  (d) a liquid suspension;
  (e) a transdermal preparation; and
  (f) a sublingual preparation.
(2) A patient may not purchase, use, or possess a cannabidiol product unless the cannabidiol product is prepared in a medicinal dosage form.
(3) A pharmacy may not purchase, possess, or sell a cannabidiol product unless the cannabidiol product is prepared in a medicinal dosage form.
(4) The department may recommend that the Legislature approve the use of an additional medicinal dosage form.

Amended by Chapter 1, 2018 Special Session 3

Effective 7/1/2019

Part 2
Miscellaneous

Effective 7/1/2019

26-65-201 Insurance coverage.

An insurance carrier, third-party administrator, or employer is not required to provide reimbursement for treatment of an individual with a cannabinoid product under this chapter.

Enacted by Chapter 452, 2018 General Session

Effective 7/1/2019

26-65-202 Rules -- Report to the Legislature.

(1) The department shall make rules regarding data to be:
  (a) collected by a physician who recommends a cannabinoid product to a patient; and
  (b) reported to the department.
(2) The department shall, before November 1 each year, report to the Health and Human Services Interim Committee on the department's administration and enforcement of this chapter.

Enacted by Chapter 452, 2018 General Session

Chapter 66
Early Childhood Utah Advisory Council

Part 1
General Provisions

26-66-101 Title.

This chapter is known as the "Early Childhood Utah Advisory Council."

Enacted by Chapter 34, 2019 General Session

26-66-102 Definitions.

As used in this chapter:

(1) "Commission" means the Governor's Early Childhood Commission created in Section 63M-13-201.

(2) "Council" means the Early Childhood Utah Advisory Council created in Section 26-66-201.

Enacted by Chapter 34, 2019 General Session

Part 2
Early Childhood Utah Advisory Council

26-66-201 Early Childhood Utah Advisory Council.

(1) There is created the Early Childhood Utah Advisory Council.

(2) The department shall make rules establishing the membership, duties, and procedures of the council in accordance with the requirements of:

(a) this chapter;

(b) the Improving Head Start for School Readiness Act of 2007, 42 U.S.C. Sec. 9837b; and

(c)Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Enacted by Chapter 34, 2019 General Session

26-66-202 Early Childhood Utah Advisory Council -- Duties.

(1) The council shall serve as an entity dedicated to improving and coordinating the quality of programs and services for children in accordance with the Improving Head Start for School Readiness Act of 2007, 42 U.S.C. Sec. 9837b.

(2) The council shall advise the commission and, on or before August 1, annually provide to the commission:

(a) a statewide assessment concerning the availability of high-quality pre-kindergarten services for children from low-income households; and

(b) a statewide strategic report addressing the activities mandated by the Improving Head Start for School Readiness Act of 2007, 42 U.S.C. Sec. 9837b, including:

(i) identifying opportunities for and barriers to collaboration and coordination among federally-funded and state-funded child health and development, child care, and early childhood education programs and services, including collaboration and coordination among state agencies responsible for administering such programs;

(ii) evaluating the overall participation of children in existing federal, state, and local child care programs and early childhood health, development, family support, and education programs;

(iii) recommending statewide professional development and career advancement plans for early childhood educators and service providers in the state, including an analysis of the capacity

and effectiveness of programs at two- and four-year public and private institutions of higher education that support the development of early childhood educators; and

(iv) recommending improvements to the state's early learning standards and high-quality comprehensive early learning standards.

(3) On or before August 1, 2020, and at least every five years thereafter, the council shall provide to the commission a statewide needs assessment concerning the quality and availability of early childhood education, health, and development programs and services for children in early childhood.

Enacted by Chapter 34, 2019 General Session

26-66-203 Compensation.

A member of the council may not receive compensation or benefits for the member's service.

Enacted by Chapter 34, 2019 General Session