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.

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) 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) 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

(1) 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) For purposes of this section:
   (a) "Health care provider" means a health care provider as defined in Section 78B-3-403 who:
       (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) 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
       (i) 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) 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) 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) 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

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

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 ongoing appropriations from the General Fund.

(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 100%.

(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) 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) 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) 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)
(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, prepaid 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


(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) 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).

(2) 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).
(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) "Family planning services" means family planning services that are provided under the state Medicaid program, including:
       (i) sexual health education and family planning counseling; and
       (ii) other medical diagnosis, treatment, or preventative care routinely provided as part of a family planning service visit.
   (b) "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
Part 5
Long Term Care Facility - Medicaid Certification

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) 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.
26-18-604 Division duties -- Reporting.

The division shall:

(1) develop and implement procedures relating to Medicaid funds and medical or hospital assistance funds to ensure that providers do not receive:
   (a) duplicate payments for the same goods or services;
   (b) payment for goods or services by resubmitting a claim for which:
      (i) payment has been disallowed on the grounds that payment would be a violation of federal or state law, administrative rule, or the state plan; and
      (ii) the decision to disallow the payment has become final;
   (c) payment for goods or services provided after a recipient's death, including payment for pharmaceuticals or long-term care; or
   (d) payment for transporting an unborn infant;

(2) 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;

(3) actively seek repayment from providers for improperly used or paid:
   (a) Medicaid funds; and
   (b) medical or hospital assistance funds;

(4) coordinate, track, and keep records of all division efforts to obtain repayment of the funds described in Subsection (3), and the results of those efforts;

(5) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the pharmaceuticals that represent the highest 45% of state Medicaid expenditures for pharmaceuticals and on an annual basis for the remaining pharmaceuticals:
   (a) tracking changes in the price of pharmaceuticals;
   (b) checking the availability and price of generic drugs;
   (c) reviewing and updating the state's maximum allowable cost list; and
   (d) comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists; and

(6) 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.

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