Effective 5/3/2023

Part 1
Health Care Assistance

26B-3-101 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 Integrated Healthcare within the department, established under Section 26B-3-102.

(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 306, 2023 General Session

26B-3-102 Division -- Creation.

There is created, within the department, the Division of Integrated Healthcare which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Children's Health Insurance Program established in Section 26B-3-902, in accordance with the provisions of this chapter and applicable federal law.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-103 State Medicaid director -- Appointment -- Responsibilities.

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

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

(a) administer the responsibilities of the division as set forth in this chapter;

(b) administer the division's budget; and

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-104 Division responsibilities -- Emphasis -- Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:
  (a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;
  (b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and
  (c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.
(2) The division shall implement and utilize cost-containment methods, where possible, which may include:
  (a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;
  (b) preadmission certification of nonemergency admissions;
  (c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;
  (d) second surgical opinions;
  (e) procedures for encouraging the use of outpatient services;
  (f) consistent with Sections 26B-3-105 and 58-17b-606, a Medicaid drug program;
  (g) coordination of benefits; and
  (h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.
(3) The state Medicaid director shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.
(4)
  (a) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, and cost avoidance.
  (b) The department shall coordinate with the Office of the Inspector General for Medicaid Services created in Section 63A-13-201 to implement Subsection (2) and to address Medicaid fraud, waste, or abuse as described in Section 63A-13-202.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-105 Medicaid drug program -- Preferred drug list.

(1) A Medicaid drug program developed by the department under Subsection 26B-3-104(2)(f):
  (a) shall, notwithstanding Subsection 26B-3-104(1)(b), be based on clinical and cost-related factors which include medical necessity as determined by a provider in accordance with administrative rules established by the Drug Utilization Review Board;
  (b) may include therapeutic categories of drugs that may be exempted from the drug program;

(c) may include placing some drugs, except the drugs described in Subsection (2), on a preferred drug list:
(i) to the extent determined appropriate by the department; and
(ii) in the manner described in Subsection (3) for psychotropic drugs;
(d) notwithstanding the requirements of Sections 26B-3-302 through 26B-3-309 regarding the 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) As used in this Subsection (2):
(i) "Immunosuppressive drug":
(A) means a drug that is used in immunosuppressive therapy to inhibit or prevent activity of the immune system to aid the body in preventing the rejection of transplanted organs and tissue; and
(B) does not include drugs used for the treatment of autoimmune disease or diseases that are most likely of autoimmune origin.
(ii) "Stabilized" means a health care provider has documented in the patient's medical chart that a patient has achieved a stable or steadfast medical state within the past 90 days using a particular psychotropic drug.
(b) A preferred drug list developed under the provisions of this section may not include an immunosuppressive drug.
(c)
(i) The state Medicaid program shall reimburse for a prescription for an immunosuppressive drug as written by the health care provider for a patient who has undergone an organ transplant.
(ii) For purposes of Subsection 58-17b-606(4), and with respect to patients who have undergone an organ transplant, the prescription for a particular immunosuppressive drug as written by a health care provider meets the criteria of demonstrating to the department a medical necessity for dispensing the prescribed immunosuppressive drug.
(d) Notwithstanding the requirements of Sections 26B-3-302 through 26B-3-309 regarding the 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) As used in this Subsection (3), "psychotropic drug" means the following classes of drugs:

(i) atypical anti-psychotic;

(ii) anti-depressant;

(iii) anti-convulsant/mood stabilizer;

(iv) anti-anxiety; and

(v) attention deficit hyperactivity disorder stimulant.

(b)

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

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

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

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

(i) establish a system to:

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

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

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

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

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

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

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

(d) Beginning October 1, 2019, the department shall eliminate the dispense as written override for the preferred drug list, and shall implement a prior authorization system for psychotropic

drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has not realized annual savings from implementing the preferred drug list for psychotropic drugs of at least $750,000 General Fund savings.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-106 Simplified enrollment and renewal process for Medicaid and other state medical programs -- Financial institutions.

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

(2)

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

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

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

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

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

(d) The department may disclose a financial record obtained from a financial institution under this section only for the purpose of, and to the extent necessary in, verifying eligibility as provided in this section and Section 26B-3-903.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-107 Dental benefits.

(1)

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

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

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

(a) ability to manage dental expenses;

(b) proven ability to handle dental insurance;

(c) efficiency of claim paying procedures;

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

(e) other criteria established by the department.

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

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

(5) The division may not award contracts to:

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

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

(6)
(a) The division may cancel the request for proposals if:
(i) there are no responsive bidders; or
(ii) the division determines that accepting the bids would increase the program's costs.
(b) If the division cancels a request for proposal or a contract that results from a request for proposal described in Subsection (6)(a), the division shall report to the Health and Human Services Interim Committee regarding the reasons for the decision.
(7)Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.
(8)
(a) The division may:
(i) establish a dental health care delivery system and payment reform pilot program for Medicaid dental benefits to increase access to cost effective and quality dental health care by increasing the number of dentists available for Medicaid dental services; and
(ii) target specific Medicaid populations or geographic areas in the state.
(b) The pilot program shall establish compensation models for dentists and dental hygienists that:
(i) increase access to quality, cost effective dental care; and
(ii) use funds from the Division of Family Health and Preparedness that are available to reimburse dentists for educational loans in exchange for the dentist agreeing to serve Medicaid and under-served populations.
(c) The division may amend the state plan and apply to the Secretary of the United States Department of Health and Human Services for waivers or pilot programs if necessary to establish the new dental care delivery and payment reform model.
(d) The division shall evaluate the pilot program's effect on the cost of dental care and access to dental care for the targeted Medicaid populations.
(9)
(a) As used in this Subsection (9), "dental hygienist" means an individual who is licensed as a dental hygienist under Section 58-69-301.
(b) The department shall reimburse a dental hygienist for dental services performed in a public health setting and in accordance with Subsection (9)(c) beginning on the earlier of:
(i) January 1, 2023; or
(ii) 30 days after the date on which the replacement of the department's Medicaid Management Information System software is complete.
(c) The department shall reimburse a dental hygienist directly for a service provided through the Medicaid program if:
(i) the dental hygienist requests to be reimbursed directly; and
(ii) the dental hygienist provides the service within the scope of practice described in Section 58-69-801.
(d) Before November 30 of each year in which the department reimburses dental hygienists in accordance with Subsection (9)(c), the department shall report to the Health and Human Services Interim Committee, for the previous fiscal year:
(i) the number and geographic distribution of dental hygienists who requested to be reimbursed directly;
(ii) the total number of Medicaid enrollees who were served by a dental hygienist who were reimbursed under this Subsection (9);
(iii) the total amount reimbursed directly to dental hygienists under this Subsection (9);
(iv) the specific services and billing codes that are reimbursed under this Subsection (9); and
(v) the aggregate amount reimbursed for each service and billing code described in Subsection (9)(d)(iv).

(e)
(i) Except as provided in this Subsection (9), nothing in this Subsection (9) shall be interpreted as expanding or otherwise altering the limitations and scope of practice for a dental hygienist.
(ii) A dental hygienist may only directly bill and receive compensation for billing codes that fall within the scope of practice of a dental hygienist.

Renumbered and Amended by Chapter 306, 2023 General Session

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

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

(2)
(a) The department shall implement the Medicaid program through administrative rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the requirements of Title XIX, and applicable federal regulations.
(b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules necessary to implement the program:
(i) the standards used by the department for determining eligibility for Medicaid services;
(ii) the services and benefits to be covered by the Medicaid program;
(iii) reimbursement methodologies for providers under the Medicaid program; and
(iv) a requirement that:
(A) a person receiving Medicaid services shall participate in the electronic exchange of clinical health records established in accordance with Section 26B-8-411 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 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 26B-3-1113, 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 Part 9, Utah Children's Health Insurance Program, the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.
(b) Before Subsection (8)(a) may be applied:
(i) the federal government shall:
(A) determine that Subsection (8)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;
(B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or

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

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

(9)

(a) As used in this Subsection (9):

(i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as defined in 42 U.S.C. Sec. 1382c(a)(1); and

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

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

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

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

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

(11)

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

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

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

(12)

(a)

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

(A) medically needy pregnant women;

(B) medically needy children; and

(C) medically needy parents and caretaker relatives.

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

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

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

(A) under the age of 26; and

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

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

(13)

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

(i) incarcerated; and

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

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

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

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

(b) that involves medical assistance under this chapter.

(15)

(a) The department may not deny or terminate eligibility for Medicaid solely because a birth mother, as that term is defined in Section 78B-6-103, considers an adoptive placement for the child or proceeds with an adoptive placement of the child.

(b) A health care provider, as that term is defined in Section 26B-3-126, may not decline payment by Medicaid for covered health and medical services provided to a birth mother, as that term is defined in Section 78B-6-103, who is enrolled in Utah's Medicaid program and who considers an adoptive placement for the child or proceeds with an adoptive placement of the child.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 466, 2023 General Session

26B-3-109 Medicaid expansion.

(1) The purpose of this section is to expand the coverage of the Medicaid program to persons who are in categories traditionally not served by that program.

(2) Within appropriations from the Legislature, the department may amend the state plan for medical assistance to provide for eligibility for Medicaid:

(a) on or after July 1, 1994, for children 12 to 17 years old who live in households below the federal poverty income guideline; and

(b) on or after July 1, 1995, for persons who have incomes below the federal poverty income guideline and who are aged, blind, or have a disability.

(3)

(a) Within appropriations from the Legislature, on or after July 1, 1996, the Medicaid program may provide for eligibility for persons who have incomes below the federal poverty income guideline.

(b) In order to meet the provisions of this subsection, the department may seek approval for a demonstration project under 42 U.S.C. Sec. 1315 from the secretary of the United States Department of Health and Human Services.

(4) The Medicaid program shall provide for eligibility for persons as required by Subsection 26B-3-113(2).

(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.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-110 Copayments by recipients -- Employer sponsored plans.

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

(2) Beginning May 1, 2006, within appropriations by the Legislature and as a means to increase health care coverage among the uninsured, the department shall take steps to promote increased participation in employer sponsored health insurance, including:
(a) maximizing the health insurance premium subsidy provided under the state's 1115 demonstration waiver by:
(i) ensuring that state funds are matched by federal funds to the greatest extent allowable; and
(ii) as the department determines appropriate, seeking federal approval to do one or more of the following:
(A) eliminate or otherwise modify the annual enrollment fee;
(B) eliminate or otherwise modify the schedule used to determine the level of subsidy provided to an enrollee each year;
(C) reduce the maximum number of participants allowable under the subsidy program; or
(D) otherwise modify the program in a manner that promotes enrollment in employer sponsored health insurance; and
(b) exploring the use of other options, including the development of a waiver under the Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-111 Income and resources from institutionalized spouses.
(1) As used in this section:
(a) "Community spouse" means the spouse of an institutionalized spouse.
(b)
(i) "Community spouse monthly income allowance" means an amount by which the minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly income otherwise available to the community spouse, determined without regard to the allowance, except as provided in Subsection (1)(b)(ii).
(ii) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse may not be less than the amount of the monthly income so ordered.
(c) "Community spouse resource allowance" is the amount of combined resources that are protected for a community spouse living in the community, which the division shall establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the United States Department of Health and Human Services.
(d) "Excess shelter allowance" for a community spouse means the amount by which the sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case of condominium or cooperative, required maintenance charge, for the community spouse's principal residence and the spouse's actual expenses for electricity, natural gas, and water utilities or, at the discretion of the department, the federal standard utility allowance under SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection (9).
(e) "Family member" means a minor dependent child, dependent parents, or dependent sibling of the institutionalized spouse or community spouse who are residing with the community spouse.
(f)
(i) "Institutionalized spouse" means a person who is residing in a nursing facility and is married to a spouse who is not in a nursing facility.

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

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

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

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

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

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

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

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

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

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

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

(7)

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) an excess shelter allowance.

(11)

(a) An institutionalized spouse or a community spouse may request a hearing with respect to the determinations described in Subsections (11)(e)(i) through (v) if an application for medical assistance has been made on behalf of the institutionalized spouse.

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

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

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

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

(i) the community spouse monthly income allowance;

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

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

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

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

(12)

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

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

(c)Part 10, Medical Benefits Recovery, does not apply if a court has entered an order against an institutionalized spouse for the support of the community spouse.

Renumbered and Amended by Chapter 306, 2023 General Session

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

(1)
(a) The department shall seek to maximize the use of Medicaid and Children's Health Insurance Program funds for assistance in the purchase of private health insurance coverage for Medicaid-eligible and non-Medicaid-eligible individuals.
(b) The department's efforts to expand the use of premium assistance shall:
(i) include, as necessary, seeking federal approval under all Medicaid and Children's Health Insurance Program premium assistance provisions of federal law, including provisions of PPACA;
(ii) give priority to, but not be limited to, expanding the state's Utah Premium Partnership for Health Insurance Program, including as required under Subsection (2); and
(iii) encourage the enrollment of all individuals within a household in the same plan, where possible, including enrollment in a plan that allows individuals within the household transitioning out of Medicaid to retain the same network and benefits they had while enrolled in Medicaid.
(2) The department shall seek federal approval of an amendment to the state's Utah Premium Partnership for Health Insurance program to adjust the eligibility determination for single adults and parents who have an offer of employer sponsored insurance. The amendment shall:
(a) be within existing appropriations for the Utah Premium Partnership for Health Insurance program; and
(b) provide that adults who are up to 200% of the federal poverty level are eligible for premium subsidies in the Utah Premium Partnership for Health Insurance program.
(3) For the fiscal year 2020-21, the department shall seek authority to increase the maximum premium subsidy per month for adults under the Utah Premium Partnership for Health Insurance program to $300.
(4) Beginning with the fiscal year 2021-22, and in each subsequent fiscal year, the department may increase premium subsidies for single adults and parents who have an offer of employer-sponsored insurance to keep pace with the increase in insurance premium costs, subject to appropriation of additional funding.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-113 Expanding the Medicaid program.
(1) As used in this section:
(a) "Federal poverty level" means the same as that term is defined in Section 26B-3-207.
(b) "Medicaid expansion" means an expansion of the Medicaid program in accordance with this section.
(c) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26B-1-315.
(2)
(a) As set forth in Subsections (2) through (5), eligibility criteria for the Medicaid program shall be expanded to cover additional low-income individuals.
(b) The department shall continue to seek approval from CMS to implement the Medicaid waiver expansion as defined in Section 26B-1-112.
(c) The department may implement any provision described in Subsections 26B-3-112(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 26B-3-127 and 63J-5-204, and in accordance with this Subsection (5), eligibility for the Medicaid program shall be expanded to include all persons in the optional Medicaid expansion population under PPACA and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance, on the earlier of:

(i) the day on which CMS approves a waiver to implement the provisions described in Subsections (5)(a)(ii)(A) and (B); or

(ii) July 1, 2020.

(c) The department shall seek a waiver, or an amendment to an existing waiver, from federal law to:

(i) implement each provision described in Subsections 26B-3-210(2)(b)(iii) through (viii) in a Medicaid expansion under this Subsection (5);

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

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

(d) The eligibility criteria in this Subsection (5) shall be construed to include all individuals eligible for the health coverage improvement program under Section 26B-3-207.

(e) 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;

(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 and Department of Workforce Services to reduce commitments and expenditures by an amount sufficient to offset the deficiency:

(A) proportionate to the share of total current fiscal year General Fund appropriations for each of those agencies; and

(B) up to 10% of each agency's total current fiscal year General Fund appropriations;

(ii) the Division of Finance shall reduce allotments to the department and Department of Workforce Services by a percentage:

(A) proportionate to the amount of the deficiency; and

(B) up to 10% of each agency's total current fiscal year General Fund appropriations; and

(iii) the Division of Finance shall deposit the total amount from the reduced allotments described in Subsection (5)(g)(ii) into the Medicaid Expansion Fund.

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

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

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

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

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

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

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

(e) as calculated in accordance with Subsections 26B-3-506(4) and 26B-3-606(2), the state's net cost of the qualified Medicaid expansion.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-114 Department standards for eligibility under Medicaid -- Funds for abortions.

(1)

(a) The department may develop standards and administer policies relating to eligibility under the Medicaid program as long as they are consistent with Subsection 26B-4-704(8).

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

(2) The department may not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.
(3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.
(4) Any person or organization that, under the guise of other medical treatment, provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

Renumbered and Amended by Chapter 306, 2023 General Session

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

(1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other government entities, contracts shall provide that other government entities, in compliance with state and federal law regarding intergovernmental transfers, transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.
(2) Contract terms shall include provisions for maintenance, administration, and service costs.
(3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation.
(4) The provisions of this section do not apply to department rules governing abortion.
(5) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-116 Liability insurance required.

The Medicaid program may not reimburse a home health agency, as defined in Section 26B-2-201, for home health services provided to an enrollee unless the home health agency has liability coverage of:
(1) at least $500,000 per incident; or
(2) an amount established by department rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-117 Federal aid -- Authority of executive director.

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

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-118 Medical vendor rates.

(1) Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division.
(2) As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-119 Enforcement of public assistance statutes.

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-120 Prohibited acts of state or local employees of Medicaid program -- Violation a misdemeanor.

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-121 Rural hospitals.

(1) As used in this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.
(2) For purposes of the Medicaid program, the division may not discriminate among rural hospitals on the basis of size.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-122 Telemedicine -- Reimbursement -- Rulemaking.

(1)

(a) As used in this section, communication by telemedicine is considered face-to-face contact between a health care provider and a patient under the state's medical assistance program if:
(i) the communication by telemedicine meets the requirements of administrative rules adopted in accordance with Subsection (3); and
(ii) the health care services are eligible for reimbursement under the state's medical assistance program.
(b) This Subsection (1) applies to any managed care organization that contracts with the state's medical assistance program.
(2) The reimbursement rate for telemedicine services approved under this section:
(a) shall be subject to reimbursement policies set by the state plan; and
(b) may be based on:
(i) a monthly reimbursement rate;
(ii) a daily reimbursement rate; or
(iii) an encounter rate.
(3) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish:
(a) the particular telemedicine services that are considered face-to-face encounters for reimbursement purposes under the state's medical assistance program; and
(b) the reimbursement methodology for the telemedicine services designated under Subsection (3)(a).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-123 Reimbursement of telemedicine services and telepsychiatric consultations.
(1) As used in this section:
(a) "Telehealth services" means the same as that term is defined in Section 26B-4-704.
(b) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.
(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 audio-only telehealth services as specified by division rule.
(5) The Medicaid program shall reimburse for telepsychiatric consultations at a rate set by the Medicaid program.

Amended by Chapter 295, 2023 General Session

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-124 Process to promote health insurance coverage for children.

(1) The department, in collaboration with the Department of Workforce Services and the State Board of Education, shall develop a process to promote health insurance coverage for a child in school when:
  (a) the child applies for free or reduced price school lunch;
  (b) a child enrolls in or registers in school; and
  (c) other appropriate school related opportunities.
(2) The department, in collaboration with the Department of Workforce Services, shall promote and facilitate the enrollment of children identified under Subsection (1) without health insurance in the Utah Children's Health Insurance Program, the Medicaid program, or the Utah Premium Partnership for Health Insurance Program.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-125 Medicaid -- Continuous eligibility -- Promoting payment and delivery reform.

(1) In accordance with Subsection (2), and within appropriations from the Legislature, the department may amend the state Medicaid plan to:
  (a) create continuous eligibility for up to 12 months for an individual who has qualified for the state Medicaid program;
  (b) provide incentives in managed care contracts for an individual to obtain appropriate care in appropriate settings; and
  (c) require the managed care system to accept the risk of managing the Medicaid population assigned to the plan amendment in return for receiving the benefits of providing quality and cost effective care.
(2) If the department amends the state Medicaid plan under Subsection (1)(a) or (b), the department:
  (a) shall ensure that the plan amendment:
    (i) is cost effective for the state Medicaid program;
    (ii) increases the quality and continuity of care for recipients; and
    (iii) calculates and transfers administrative savings from continuous enrollment from the Department of Workforce Services to the department; and
  (b) may limit the plan amendment under Subsection (1)(a) or (b) to select geographic areas or specific Medicaid populations.
(3) The department may seek approval for a state plan amendment, waiver, or a demonstration project from the Secretary of the United States Department of Health and Human Services if necessary to implement a plan amendment under Subsection (1)(a) or (b).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-126 Patient notice of health care provider privacy practices.

(1)
  (a) For purposes of this section:
    (i) "Health care provider" means a health care provider as defined in Section 78B-3-403 who:
      (A) receives payment for medical services from the Medicaid program established in this chapter, or the Children's Health Insurance Program established in Section 26B-3-902; 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 Section 26B-3-902, 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).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-127 Optional Medicaid expansion.

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

(a) the department expands Medicaid in accordance with Section 26B-3-210; or

(b)

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

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

(2)

(a) The department shall request approval from CMS for waivers from federal statutory and regulatory law necessary to implement the health coverage improvement program under Section 26B-3-207.

(b) The health coverage improvement program under Section 26B-3-207 is not subject to the requirements in Subsection (1).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-128 Medicaid vision services -- Request for proposals.

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-129 Review of claims -- Audit and investigation procedures.

(1)
(a) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consultation with providers and health care professionals subject to audit and investigation under the state Medicaid program, to establish procedures for audits and investigations that are fair and consistent with the duties of the department as the single state agency responsible for the administration of the Medicaid program under Section 26B-3-108 and Title XIX of the Social Security Act.
(b) If the providers and health care professionals do not agree with the rules proposed or adopted by the department under Subsection (1)(a), the providers or health care professionals may:
(i) request a hearing for the proposed administrative rule or seek any other remedies under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
(ii) request a review of the rule by the Legislature's Administrative Rules Review and General Oversight Committee created in Section 63G-3-501.
(2) The department shall:
(a) notify and educate providers and health care professionals subject to audit and investigation under the Medicaid program of the providers' and health care professionals' responsibilities and rights under the administrative rules adopted by the department under the provisions of this section;
(b) ensure that the department, or any entity that contracts with the department to conduct audits:
(i) has on staff or contracts with a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited; and
(ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if the provider who is the subject of the audit disputes the findings of the audit;
(c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, as defined in Section 63A-13-102, unless:
(i) there is a determination that the level of payment error involving the provider exceeds a 10% error rate:
(A) for a sample of claims for a particular service code; and
(B) over a three year period of time;
(ii) documented education intervention has failed to correct the level of payment error; and
(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in reimbursement for a particular service code on an annual basis; and
(d) require that any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.
(3)
(a) If the department, or a contractor on behalf of the department:
(i) intends to implement the use of extrapolation as a method of auditing claims, the department shall, prior to adopting the extrapolation method of auditing, report its intent to use extrapolation to the Social Services Appropriations Subcommittee; and
(ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the department or the contractor may use extrapolation only for the service code associated with the findings under Subsections (2)(c)(i) through (iii).
(b)
(i) If extrapolation is used under this section, a provider may, at the provider's option, appeal the results of the audit based on:
(A) each individual claim; or
(B) the extrapolation sample.

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-130 Medicaid intergovernmental transfer report -- Approval requirements.

(1) As used in this section:

(a)

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

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

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

(ii) "Intergovernmental transfer" does not include:

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

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

(b)

(i) "Intergovernmental transfer program" means a federally approved reimbursement program or category that is authorized by the Medicaid state plan or waiver authority for intergovernmental transfers.

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

(c) "Local government entity" means a county, city, town, special service district, special 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 2, Part 2, Health Care Facility Licensing and Inspection.

(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 16, 2023 General Session
Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-131 Screening, Brief Intervention, and Referral to Treatment Medicaid reimbursement.
(1) As used in this section:
(a) "Controlled substance prescriber" means a controlled substance prescriber, as that term is defined in Section 58-37-6.5, who:
(i) has a record of having completed SBIRT training, in accordance with Subsection 58-37-6.5(2), before providing the SBIRT services; and
(ii) is a Medicaid enrolled health care provider.
(b) "SBIRT" means the same as that term is defined in Section 58-37-6.5.
(2) The department shall reimburse a controlled substance prescriber who provides SBIRT services to a Medicaid enrollee who is 13 years old or older for the SBIRT services.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-132 Prescribing policies for opioid prescriptions.
(1) The department may implement a prescribing policy for certain opioid prescriptions that is substantially similar to the prescribing policies required in Section 31A-22-615.5.
(2) The department may amend the state program and apply for waivers for the state program, if necessary, to implement Subsection (1).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-133 Reimbursement for long-acting reversible contraception immediately following childbirth.

(1) As used in this section, "long-acting reversible contraception" means a contraception method that requires administration less than once per month, including:
  (a) an intrauterine device; and
  (b) a contraceptive implant.
(2) The division shall separately identify and reimburse, from other labor and delivery services within the Medicaid program, the provision and insertion of long-acting reversible contraception immediately after childbirth.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-134 Coverage of exome sequence testing.

(1) As used in this section, "exome sequence testing" means a genomic technique for sequencing the genome of an individual for diagnostic purposes.
(2) The Medicaid program shall reimburse for exome sequence testing:
  (a) for an enrollee who:
    (i) is younger than 21 years old; 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.

Renumbered and Amended by Chapter 306, 2023 General Session

Superseded 7/1/2024

26B-3-135 Reimbursement for nonemergency secured behavioral health transport providers.

The department may not reimburse a nonemergency secured behavioral health transport provider that is designated under Section 26B-4-117.

Renumbered and Amended by Chapter 306, 2023 General Session

Effective 7/1/2024

26B-3-135 Reimbursement for nonemergency secured behavioral health transport providers.

The department may not reimburse a nonemergency secured behavioral health transport provider that is designated under Section 53-2d-403.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 310, 2023 General Session

26B-3-136 Children's Health Care Coverage Program.

(1) As used in this section:

(a) "CHIP" means the Children's Health Insurance Program created in Section 26B-3-902.
(b) "Program" means the Children's Health Care Coverage Program created in Subsection (2).
(2)
(a) There is created the Children's Health Care Coverage Program within the department.
(b) The purpose of the program is to:
(i) promote health insurance coverage for children in accordance with Section 26B-3-124;
(ii) conduct research regarding families who are eligible for Medicaid and CHIP to determine awareness and understanding of available coverage;
(iii) analyze trends in disenrollment and identify reasons that families may not be renewing enrollment, including any barriers in the process of renewing enrollment;
(iv) administer surveys to recently enrolled CHIP and children's Medicaid enrollees to identify:
(A) how the enrollees learned about coverage; and
(B) any barriers during the application process;
(v) develop promotional material regarding CHIP and children's Medicaid eligibility, including outreach through social media, video production, and other media platforms;
(vi) identify ways that the eligibility website for enrollment in CHIP and children's Medicaid can be redesigned to increase accessibility and enhance the user experience;
(vii) identify outreach opportunities, including partnerships with community organizations including:
(A) schools;
(B) small businesses;
(C) unemployment centers;
(D) parent-teacher associations; and
(E) youth athlete clubs and associations; and
(viii) develop messaging to increase awareness of coverage options that are available through the department.
(3)
(a) The department may not delegate implementation of the program to a private entity.
(b) Notwithstanding Subsection (3)(a), the department may contract with a media agency to conduct the activities described in Subsection (2)(b)(iv) and (vii).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-137 Reimbursement for diabetes prevention program.
(1) As used in this section, "DPP" means the National Diabetes Prevention Program developed by the United States Centers for Disease Control and Prevention.
(2) Beginning July 1, 2022, the Medicaid program shall reimburse a provider for an enrollee's participation in the DPP if the enrollee:
(a) meets the DPP's eligibility requirements; and
(b) has not previously participated in the DPP after July 1, 2022, while enrolled in the Medicaid program.
(3) Subject to appropriation, the Medicaid program may set the rate for reimbursement.
(4) The department may apply for a state plan amendment if necessary to implement this section.
(5)
(a) On or after July 1, 2025, but before October 1, 2025, the department shall provide a written report regarding the efficacy of the DPP and reimbursement under this section to the Health and Human Services Interim Committee.
(b) The report described in Subsection (5)(a) shall include:

(i) the total number of enrollees with a prediabetic condition as of July 1, 2022;
(ii) the total number of enrollees as of July 1, 2022, with a diagnosis of type 2 diabetes;
(iii) the total number of enrollees who participated in the DPP;
(iv) the total cost incurred by the state to implement this section; and
(v) any conclusions that can be drawn regarding the impact of the DPP on the rate of type 2 diabetes for enrollees.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-138 Behavioral health delivery working group.

(1) As used in this section, "targeted adult Medicaid program" means the same as that term is defined in Section 26B-3-207.
(2) On or before May 31, 2022, the department shall convene a working group to collaborate with the department on:
(a) establishing specific and measurable metrics regarding:
(i) compliance of managed care organizations in the state with federal Medicaid managed care requirements;
(ii) timeliness and accuracy of authorization and claims processing in accordance with Medicaid policy and contract requirements;
(iii) reimbursement by managed care organizations in the state to providers to maintain adequacy of access to care;
(iv) availability of care management services to meet the needs of Medicaid-eligible individuals enrolled in the plans of managed care organizations in the state; and
(v) timeliness of resolution for disputes between a managed care organization and the managed care organization's providers and enrollees;
(b) improving the delivery of behavioral health services in the Medicaid program;
(c) proposals to implement the delivery system adjustments authorized under Subsection 26B-3-223(3); and
(d) issues that are identified by managed care organizations, behavioral health service providers, and the department.
(3) The working group convened under Subsection (2) shall:
(a) meet quarterly; and
(b) consist of at least the following individuals:
(i) the executive director or the executive director's designee;
(ii) for each Medicaid accountable care organization with which the department contracts, an individual selected by the accountable care organization;
(iii) five individuals selected by the department to represent various types of behavioral health services providers, including, at a minimum, individuals who represent providers who provide the following types of services:
(A) acute inpatient behavioral health treatment;
(B) residential treatment;
(C) intensive outpatient or partial hospitalization treatment; and
(D) general outpatient treatment;
(iv) a representative of an association that represents behavioral health treatment providers in the state, designated by the Utah Behavioral Healthcare Council convened by the Utah Association of Counties;
(v) a representative of an organization representing behavioral health organizations;

(vi) the chair of the Utah Substance Use and Mental Health Advisory Council created in Section 63M-7-301;
(vii) a representative of an association that represents local authorities who provide public behavioral health care, designated by the department;
(viii) one member of the Senate, appointed by the president of the Senate; and
(ix) one member of the House of Representatives, appointed by the speaker of the House of Representatives.
(4) The working group convened under this section shall recommend to the department:
(a) specific and measurable metrics under Subsection (2)(a);
(b) how physical and behavioral health services may be integrated for the targeted adult Medicaid program, including ways the department may address issues regarding:
(i) filing of claims;
(ii) authorization and reauthorization for treatment services;
(iii) reimbursement rates; and
(iv) other issues identified by the department, behavioral health services providers, or Medicaid managed care organizations;
(c) ways to improve delivery of behavioral health services to enrollees, including changes to statute or administrative rule; and
(d) wraparound service coverage for enrollees who need specific, nonclinical services to ensure a path to success.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-139 Adjudicative proceedings related to Medicaid funds.
(1) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to recovery of Medicaid funds:
(a) the presiding officer shall be designated by the executive director of the department and report directly to the executive director or, in the discretion of the executive director, report directly to the director of the Office of Internal Audit; and
(b) the decision of the presiding officer is the recommended decision to the executive director of the department or a designee of the executive director who is not in the division.
(2) Subsection (1) does not apply to hearings conducted by the Department of Workforce Services relating to medical assistance eligibility determinations.
(3) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to Medicaid or Medicaid funds, the following may attend and present evidence or testimony at the proceeding:
(a) the director of the Office of Internal Audit, or the director's designee; and
(b) the inspector general of Medicaid services or the inspector general's designee.
(4) In relation to a proceeding of the department under Title 63G, Chapter 4, Administrative Procedures Act, a person may not, outside of the actual proceeding, attempt to influence the decision of the presiding officer.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-140 Medical assistance accountability -- Division duties -- Reporting.
(1) As used in this section:
(a) "Abuse" means:
(i) an action or practice that:

(A) is inconsistent with sound fiscal, business, or medical practices; and
(B) results, or may result, in unnecessary Medicaid related costs or other medical or hospital assistance costs; or
(ii) reckless or negligent upcoding.
(b) "Fraud" means intentional or knowing:
(i) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, claims, reimbursement, or practice; or
(ii) deception or misrepresentation in relation to medical or hospital assistance funds, costs, claims, reimbursement, or practice.
(c) "Upcoding" means assigning an inaccurate billing code for a service that is payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.
(d) "Waste" means overutilization of resources or inappropriate payment.
(2) The division shall:
(a) develop and implement procedures relating to Medicaid funds and medical or hospital assistance funds to ensure that providers do not receive:
(i) duplicate payments for the same goods or services;
(ii) payment for goods or services by resubmitting a claim for which:
(A) payment has been disallowed on the grounds that payment would be a violation of federal or state law, administrative rule, or the state plan; and
(B) the decision to disallow the payment has become final;
(iii) payment for goods or services provided after a recipient's death, including payment for pharmaceuticals or long-term care; or
(iv) payment for transporting an unborn infant;
(b) consult with CMS, other states, and the Office of Inspector General of Medicaid Services to determine and implement best practices for discovering and eliminating fraud, waste, and abuse of Medicaid funds and medical or hospital assistance funds;
(c) actively seek repayment from providers for improperly used or paid:
(i) Medicaid funds; and
(ii) medical or hospital assistance funds;
(d) coordinate, track, and keep records of all division efforts to obtain repayment of the funds described in Subsection (2)(c), and the results of those efforts;
(e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the pharmaceuticals that represent the highest 45% of state Medicaid expenditures for pharmaceuticals and on an annual basis for the remaining pharmaceuticals:
(i) tracking changes in the price of pharmaceuticals;
(ii) checking the availability and price of generic drugs;
(iii) reviewing and updating the state's maximum allowable cost list; and
(iv) comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists; and
(f) provide training, on an annual basis, to the employees of the division who make decisions on billing codes, or who are in the best position to observe and identify upcoding, in order to avoid and detect upcoding.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-141 Medical assistance from division or Department of Workforce Services and compliance under adoption assistance interstate compact -- Penalty for fraudulent claim.

(1) As used in this section:
  (a) "Adoption assistance" means the same as that term is defined in Section 80-2-809.
  (b) "Adoption assistance agreement" means the same as that term is defined in Section 80-2-809.
  (c) "Adoption assistance interstate compact" means an agreement executed by the Division of Child and Family Services with any other state in accordance with Section 80-2-809.

(2)
  (a) A child who is a resident of this state and is the subject of an adoption assistance interstate compact is entitled to receive medical assistance from the division and the Department of Workforce Services by filing a certified copy of the child's adoption assistance agreement with the division or the Department of Workforce Services.
  (b) The adoptive parent of the child described in Subsection (2)(a) shall annually provide the division or the Department of Workforce Services with evidence verifying that the adoption assistance agreement is still effective.

(3) The Department of Workforce Services shall consider the recipient of medical assistance under this section as the Department of Workforce Services does any other recipient of medical assistance under an adoption assistance agreement executed by the Division of Child and Family Services.

(4)
  (a) A person may not submit a claim for payment or reimbursement under this section that the person knows is false, misleading, or fraudulent.
  (b) A violation of Subsection (4)(a) is a third degree felony.

(5) The division and the Department of Workforce Services shall:
  (a) cooperate with the Division of Child and Family Services in regard to an adoption assistance interstate compact; and
  (b) comply with an adoption assistance interstate compact.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-142 Long-acting injectables.

(1) With respect to payments by the Medicaid program for long-acting injectable typical and atypical antipsychotics, the department shall report on the following to the Health and Human Services Interim Committee before November 1, 2023:
  (a) options for payment, including the benefits and cost of each option; and
  (b) whether payment should be included in a bundled payment made to a hospital.

(2) The department shall prepare the report with input from health care providers.

Enacted by Chapter 295, 2023 General Session