Effective 5/3/2023

Part 2
Medicaid Waivers

26B-3-201 Independent foster care adolescents.

(1) As used in this section, an "independent foster care adolescent" includes any individual who reached 18 years old while in the custody of the department if the department was the primary case manager, or a federally recognized Indian tribe.

(2) An independent foster care adolescent is eligible, when funds are available, for Medicaid coverage until the individual reaches 21 years old.

Amended by Chapter 284, 2024 General Session

26B-3-202 Waivers to maximize replacement of fee-for-service delivery model -- Cost of mandated program changes.

(1) The department shall develop a waiver program in the Medicaid program to replace the fee-for-service delivery model with one or more risk-based delivery models.

(2) The waiver program shall:

(a) restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the waiver program, maintain or improve recipient health status;

(b) restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to:

(i) maintain or improve their health status; and

(ii) use providers that deliver the most appropriate services at the lowest cost;

(c) identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that:

(i) pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter; and

(ii) reward providers for delivering services that make the most positive contribution to a recipient's health status;

(d) limit total annual per-patient-per-month expenditures for services delivered through fee-for-service arrangements to total annual per-patient-per-month expenditures for services delivered through risk-based arrangements covering similar recipient populations and services; and

(e) except as provided in Subsection (4), limit the rate of growth in per-patient-per-month General Fund expenditures for the program to the rate of growth in General Fund expenditures for all other programs, when the rate of growth in the General Fund expenditures for all other programs is greater than zero.

(3) To the extent possible, the department shall operate the waiver program with the input of stakeholder groups representing those who will be affected by the waiver program.

(4)

(a) For purposes of this Subsection (4), "mandated program change" shall be determined by the department in consultation with the Medicaid accountable care organizations, and may

include a change to the state Medicaid program that is required by state or federal law, state or federal guidance, policy, or the state Medicaid plan.

(b) A mandated program change shall be included in the base budget for the Medicaid program for the fiscal year in which the Medicaid program adopted the mandated program change.

(c) The mandated program change is not subject to the limit on the rate of growth in per-patient-per-month General Fund expenditures for the program established in Subsection (2)(e), until the fiscal year following the fiscal year in which the Medicaid program adopted the mandated program change.

(5) A managed care organization or a pharmacy benefit manager that provides a pharmacy benefit to an enrollee shall establish a unique group number, payment classification number, or bank identification number for each Medicaid managed care organization plan for which the managed care organization or pharmacy benefit manager provides a pharmacy benefit.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-203 Base budget appropriations for Medicaid accountable care organizations and behavioral health plans -- Forecast of behavioral health services cost, behavioral health plans, and ABA services -- Forecast of behavioral health services cost.

(1) As used in this section:

(a) "ABA service" means a service applying applied behavior analysis, as that term is defined in Section 31A-22-642.

(b) "ABA service reimbursement rate" means the Medicaid reimbursement rate developed by the division, in accordance with Part 1, Health Care Assistance, and paid to a provider for providing an ABA service.

(c) "ACO" means a Medicaid accountable care organization that contracts with the state's Medicaid program for:

(i) physical health services; or

(ii) integrated physical and behavioral health services.

(d) "Base budget" means the same as that term is defined in legislative rule.

(e) "Behavioral health plan" means a managed care or fee-for-service delivery system that contracts with or is operated by the department to provide behavioral health services to Medicaid eligible individuals.

(f) "Behavioral health services" means mental health or substance use treatment or services.

(g) "General Fund growth factor" means the amount determined by dividing the next fiscal year ongoing General Fund revenue estimate by current fiscal year ongoing appropriations from the General Fund.

(h) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal year ongoing General Fund revenue estimate identified by the Executive Appropriations Committee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal Analyst in preparing budget recommendations.

(i) "Member" means an enrollee.

(j) "PMPM" means per-member-per-month funding.

(2) If the General Fund growth factor is less than 100%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by 100%.

(3) If the General Fund growth factor is greater than or equal to 100%, but less than 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the

department in an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by the General Fund growth factor.

(4) If the General Fund growth factor is greater than or equal to 102%, the next fiscal year base budget shall, subject to Subsection (5):

(a) in fiscal years 2025 and 2026:

(i) include an appropriation to the department in an amount that would, prior to the application of Subsection (4)(a)(ii), allow the department to ensure that the next fiscal year PMPMs for ACOs and behavioral health plans is greater than or equal to the current fiscal year PMPMs for the ACOs and behavioral health plans multiplied by 102%;

(ii) subject to Subsection (4)(a)(iii), allocate the amount appropriated under Subsection (4)(a)(i) to provide substantially the same year-over-year percentage point increase to:

(A) the PMPMs for ACOs and behavioral health plans; and

(B) each ABA service reimbursement rate; and

(iii) for the initial appropriation under Subsection (4)(a)(i), prior to providing the percentage point increases under Subsection (4)(a)(ii), allocate from the total amount appropriated under Subsection (4)(a)(i) an amount necessary to increase and substantially equalize each of the ABA service reimbursement rates with a corresponding reimbursement rate paid for providing the same or substantially similar service under an ACO or a behavioral health plan; and

(b) beginning in fiscal year 2027, include an appropriation to the department in an amount necessary to ensure that the next fiscal year PMPMs for ACOs and behavioral health plans is greater than or equal to the current fiscal year PMPMs for the ACOs and the behavioral health plans multiplied by 102%, and less than or equal to the current fiscal year PMPMs for the ACOs and the behavioral health plans multiplied by the General Fund growth factor.

(5) The appropriations provided to the department for behavioral health plans under this section shall be reduced by the amount contributed by counties in the current fiscal year for behavioral health plans in accordance with Subsections 17-43-201(5)(k) and 17-43-301(6)(a)(x).

(6) In order for the department to estimate the impact of Subsections (2) through (4) before identification of the next fiscal year ongoing General Fund revenue estimate, the Governor's Office of Planning and Budget shall, in cooperation with the Office of the Legislative Fiscal Analyst, develop an estimate of ongoing General Fund revenue for the next fiscal year and provide the estimate to the department no later than November 1 of each year.

(7) The Office of the Legislative Fiscal Analyst shall include an estimate of the cost of behavioral health services in any state Medicaid funding or savings forecast that is completed in coordination with the department and the Governor's Office of Planning and Budget.

Amended by Chapter 264, 2024 General Session
Amended by Chapter 284, 2024 General Session

26B-3-204 Incentives to appropriately use emergency department services.

(1)

(a) This section applies to the Medicaid program and to the Utah Children's Health Insurance Program created in Section 26B-3-902.

(b) As used in this section:

(i) "Managed care organization" means a comprehensive full risk managed care delivery system that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through a managed care plan.

(ii) "Managed care plan" means a risk-based delivery service model authorized by Section 26B-3-202 and administered by a managed care organization.

(iii) "Non-emergent care":

(A) means use of the emergency department to receive health care that is non-emergent as defined by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and the Emergency Medical Treatment and Active Labor Act; and

(B) does not mean the medical services provided to an individual required by the Emergency Medical Treatment and Active Labor Act, including services to conduct a medical screening examination to determine if the recipient has an emergent or non-emergent condition.

(iv) "Professional compensation" means payment made for services rendered to a Medicaid recipient by an individual licensed to provide health care services.

(v) "Super-utilizer" means a Medicaid recipient who has been identified by the recipient's managed care organization as a person who uses the emergency department excessively, as defined by the managed care organization.

(2)

(a) A managed care organization may, in accordance with Subsections (2)(b) and (c):

(i) audit emergency department services provided to a recipient enrolled in the managed care plan to determine if non-emergent care was provided to the recipient; and

(ii) establish differential payment for emergent and non-emergent care provided in an emergency department.

(b)

(i) The differential payments under Subsection (2)(a)(ii) do not apply to professional compensation for services rendered in an emergency department.

(ii) Except in cases of suspected fraud, waste, and abuse, a managed care organization's audit of payment under Subsection (2)(a)(i) is limited to the 18-month period of time after the date on which the medical services were provided to the recipient. If fraud, waste, or abuse is alleged, the managed care organization's audit of payment under Subsection (2)(a)(i) is limited to three years after the date on which the medical services were provided to the recipient.

(c) The audits and differential payments under Subsections (2)(a) and (b) apply to services provided to a recipient on or after July 1, 2015.

(3) A managed care organization shall:

(a) use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all Medicaid or CHIP recipients enrolled in the managed care plan;

(b) provide viable alternatives for increasing primary care provider reimbursement rates to incentivize after hours primary care access for recipients; and

(c) report to the department on how the managed care organization complied with this Subsection (3).

(4) The department may:

(a) through administrative rule adopted by the department, develop quality measurements that evaluate a managed care organization's delivery of:

(i) appropriate emergency department services to recipients enrolled in the managed care plan;

(ii) expanded primary care and urgent care for recipients enrolled in the managed care plan, with consideration of the managed care organization's:

(A) delivery of primary care, urgent care, and after hours care through means other than the emergency department;

(B) recipient access to primary care providers and community health centers including evening and weekend access; and
(C) other innovations for expanding access to primary care; and
(iii) quality of care for the managed care plan members;
(b) compare the quality measures developed under Subsection (4)(a) for each managed care organization; and
(c) develop, by administrative rule, an algorithm to determine assignment of new, unassigned recipients to specific managed care plans based on the plan's performance in relation to the quality measures developed pursuant to Subsection (4)(a).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-205 Long-term care insurance partnership.
(1) As used in this section:
(a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec. 7702B(b).
(b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec. 1396p(b)(1)(C)(iii).
(c) "State plan amendment" means an amendment to the state Medicaid plan drafted by the department in compliance with this section.
(2) The department shall seek federal approval of a state plan amendment that creates a qualified long-term care insurance partnership.
(3) The department may make rules to comply with federal laws and regulations relating to qualified long-term care insurance partnerships and qualified long-term care insurance contracts.

Amended by Chapter 284, 2024 General Session

26B-3-206 Medicaid waiver for children with disabilities and complex medical needs.
(1) As used in this section:
(a) "Additional eligibility criteria" means the additional eligibility criteria set by the department under Subsection (4)(e).
(b) "Complex medical condition" means a physical condition of an individual that:
(i) results in severe functional limitations for the individual; and
(ii) is likely to:
(A) last at least 12 months; or
(B) result in death.
(c) "Program" means the program for children with complex medical conditions created in Subsection (3).
(d) "Qualified child" means a child who:
(i) is less than 19 years old;
(ii) is diagnosed with a complex medical condition;
(iii) has a condition that meets the definition of disability in 42 U.S.C. Sec. 12102; and
(iv) meets the additional eligibility criteria.
(2) The department shall apply for a Medicaid home and community-based waiver with CMS to implement, within the state Medicaid program, the program described in Subsection (3).
(3) If the waiver described in Subsection (2) is approved, the department shall offer a program that:
(a) as funding permits, provides treatment for qualified children;
(b) accepts applications for the program on an ongoing basis;

(c) requires periodic reevaluations of an enrolled child's eligibility and other applicants or eligible children waiting for services in the program based on the additional eligibility criteria; and
(d) at the time of reevaluation, allows the department to disenroll a child if the child is no longer a qualified child.
(4) The department shall:
(a) establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, criteria to prioritize qualified children's participation in the program based on the following factors, in the following priority order:
(i) the complexity of a qualified child's medical condition; and
(ii) the financial needs of the qualified child and the qualified child's family;
(b) convene a public process to determine the benefits and services to offer a qualified child under the program;
(c) evaluate, on an ongoing basis, the cost and effectiveness of the program;
(d) if funding for the program is reduced, develop an evaluation process to reduce the number of children served based on the participation criteria established under Subsection (4)(a); and
(e) establish, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, additional eligibility criteria based on the factors described in Subsections (4)(a)(i) and (ii).

Amended by Chapter 286, 2023 General Session
Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-207 Health coverage improvement program -- Eligibility -- Annual report -- Expansion of eligibility for adults with dependent children.

(1) As used in this section:
(a) "Adult in the expansion population" means an individual who:
(i) is described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and
(ii) is not otherwise eligible for Medicaid as a mandatory categorically needy individual.
(b) "Enhancement waiver program" means the Primary Care Network enhancement waiver program described in Section 26B-3-211.
(c) "Federal poverty level" means the poverty guidelines established by the Secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).
(d) "Health coverage improvement program" means the health coverage improvement program described in Subsections (3) through (9).
(e) "Homeless":
(i) means an individual who is chronically homeless, as determined by the department; and
(ii) includes someone who was chronically homeless and is currently living in supported housing for the chronically homeless.
(f) "Income eligibility ceiling" means the percent of federal poverty level:
(i) established by the state in an appropriations act adopted pursuant to Title 63J, Chapter 1, Budgetary Procedures Act; and
(ii) under which an individual may qualify for Medicaid coverage in accordance with this section.
(g) "Targeted adult Medicaid program" means the program implemented by the department under Subsections (5) through (7).
(2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to allow temporary residential treatment for substance use, for the traditional Medicaid population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan,

as approved by CMS and as long as the county makes the required match under Section 17-43-201.

(3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to increase the income eligibility ceiling to a percentage of the federal poverty level designated by the department, based on appropriations for the program, for an individual with a dependent child.

(4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an amendment of existing waivers, from federal statutory and regulatory law necessary for the state to implement the health coverage improvement program in the Medicaid program in accordance with this section.

(5)

(a) An adult in the expansion population is eligible for Medicaid if the adult meets the income eligibility and other criteria established under Subsection (6).

(b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:

(i) through the traditional fee for service Medicaid model in counties without Medicaid accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented and subject to Section 26B-3-223;

(ii) except as provided in Subsection (5)(b)(iii), for behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;

(iii) that, subject to Section 26B-3-223, integrates behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model; and

(iv) that permits temporary residential treatment for substance use in a short term, non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan.

(6)

(a) An individual is eligible for the health coverage improvement program under Subsection (5) if:

(i) at the time of enrollment, the individual's annual income is below the income eligibility ceiling established by the state under Subsection (1)(f); and

(ii) the individual meets the eligibility criteria established by the department under Subsection (6)(b).

(b) Based on available funding and approval from CMS, the department shall select the criteria for an individual to qualify for the Medicaid program under Subsection (6)(a)(ii), based on the following priority:

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

(A) involved in the justice system through probation, parole, or court ordered treatment; and

(B) in need of substance use treatment or mental health treatment, as determined by the department; or

(iii) if funding is available, an individual in need of substance use treatment or mental health treatment, as determined by the department.

(c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b) may remain on the Medicaid program for a 12-month certification period as defined by the department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall not apply to an individual during the 12-month certification period.

(7) The state may request a modification of the income eligibility ceiling and other eligibility criteria under Subsection (6) each fiscal year based on projected enrollment, costs to the state, and the state budget.

(8) The current Medicaid program and the health coverage improvement program, when implemented, shall coordinate with a state prison or county jail to expedite Medicaid enrollment for an individual who is released from custody and was eligible for or enrolled in Medicaid before incarceration.
(9) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to provide matching funds to the state for the cost of providing Medicaid services to newly enrolled individuals who qualify for Medicaid coverage under the health coverage improvement program under Subsection (6).
(10) If the enhancement waiver program is implemented, the department:
(a) may not accept any new enrollees into the health coverage improvement program after the day on which the enhancement waiver program is implemented;
(b) shall transition all individuals who are enrolled in the health coverage improvement program into the enhancement waiver program;
(c) shall suspend the health coverage improvement program within one year after the day on which the enhancement waiver program is implemented;
(d) shall, within one year after the day on which the enhancement waiver program is implemented, use all appropriations for the health coverage improvement program to implement the enhancement waiver program; and
(e) shall work with CMS to maintain any waiver for the health coverage improvement program while the health coverage improvement program is suspended under Subsection (10)(c).
(11) If, after the enhancement waiver program takes effect, the enhancement waiver program is repealed or suspended by either the state or federal government, the department shall reinstate the health coverage improvement program and continue to accept new enrollees into the health coverage improvement program in accordance with the provisions of this section.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-208 Medicaid waiver for delivery of adult dental services.
(1)
(a) Before June 30, 2016, the department shall ask CMS to grant waivers from federal statutory and regulatory law necessary for the Medicaid program to provide dental services in the manner described in Subsection (2)(a).
(b) Before June 30, 2018, the department shall submit to CMS a request for waivers, or an amendment of existing waivers, from federal law necessary for the state to provide dental services, in accordance with Subsections (2)(b)(i) and (d) through (f), to an individual described in Subsection (2)(b)(i).
(c) Before June 30, 2019, the department shall submit to CMS a request for waivers, or an amendment to existing waivers, from federal law necessary for the state to:
(i) provide dental services, in accordance with Subsections (2)(b)(ii) and (d) through (f) to an individual described in Subsection (2)(b)(ii); and
(ii) provide the services described in Subsection (2)(g).
(d) On or before January 1, 2024, the department shall submit to CMS a request for waivers, or an amendment of existing waivers, from federal law necessary for the state to provide dental services, in accordance with Subsections (2)(b)(iii) and (d) through (f), to an individual described in Subsection (2)(b)(iii).
(2)

(a) To the extent funded, the department shall provide dental services to only blind or disabled individuals, as defined in 42 U.S.C. Sec. 1382c(a)(1), who are 18 years old or older and eligible for the program.
(b) Notwithstanding Subsection (2)(a):
(i) if a waiver is approved under Subsection (1)(b), the department shall provide dental services to an individual who:
(A) qualifies for the health coverage improvement program described in Section 26B-3-207; and
(B) is receiving treatment in a substance abuse treatment program, as defined in Section 26B-2-101, licensed under Chapter 2, Part 1, Human Services Programs and Facilities;
(ii) if a waiver is approved under Subsection (1)(c)(i), the department shall provide dental services to an individual who is an aged individual as defined in 42 U.S.C. Sec. 1382c(a)(1); and
(iii) if a waiver is approved under Subsection (1)(d), the department shall provide dental services to an individual who is:
(A) not described in Subsection (2)(a);
(B) not described in Subsection (2)(b)(i);
(C) not described in Subsection (2)(b)(ii);
(D) not pregnant;
(E) 21 years old or older; and
(F) eligible for full services through the Medicaid program.
(c) To the extent possible, services to individuals described in Subsection (2)(a) shall be provided through the University of Utah School of Dentistry and the University of Utah School of Dentistry's associated statewide network.
(d) The department shall provide the services to individuals described in Subsection (2)(b):
(i) by contracting with an entity that:
(A) has demonstrated experience working with individuals who are being treated for both a substance use disorder and a major oral health disease;
(B) operates a program, targeted at the individuals described in Subsection (2)(b), that has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals described in Subsection (2)(b);
(C) is willing to pay for an amount equal to the program's non-federal share of the cost of providing dental services to the population described in Subsection (2)(b); and
(D) is willing to pay all state costs associated with applying for the waiver described in Subsection (1)(b) and administering the program described in Subsection (2)(b); and
(ii) through a fee-for-service payment model.
(e) The entity that receives the contract under Subsection (2)(d)(i) shall cover all state costs of the program described in Subsection (2)(b).
(f) Each fiscal year, the University of Utah School of Dentistry shall, in compliance with state and federal regulations regarding intergovernmental transfers, transfer funds to the program in an amount equal to the program's non-federal share of the cost of providing services under this section through the school during the fiscal year.
(g) If a waiver is approved under Subsection (1)(c)(ii), the department shall provide coverage for porcelain and porcelain-to-metal crowns if the services are provided:
(i) to an individual who qualifies for dental services under Subsection (2)(b); and
(ii) by an entity that covers all state costs of:
(A) providing the coverage described in this Subsection (2)(g); and
(B) applying for the waiver described in Subsection (1)(c).

(h) Where possible, the department shall ensure that dental services described in Subsection (2)(a) that are not provided by the University of Utah School of Dentistry or the University of Utah School of Dentistry's associated network are provided:
(i) through free-for-service reimbursement until July 1, 2018; and
(ii) after July 1, 2018, through the method of reimbursement used by the division for Medicaid dental benefits.
(i) Subject to appropriations by the Legislature, and as determined by the department, the scope, amount, duration, and frequency of services provided under this section may be limited.
(3)
(a) If the waivers requested under Subsection (1)(a) are granted, the Medicaid program shall begin providing dental services in the manner described in Subsection (2) no later than July 1, 2017.
(b) If the waivers requested under Subsection (1)(b) are granted, the Medicaid program shall begin providing dental services to the population described in Subsection (2)(b) within 90 days from the day on which the waivers are granted.
(c) If the waivers requested under Subsection (1)(c)(i) are granted, the Medicaid program shall begin providing dental services to the population described in Subsection (2)(b)(ii) within 90 days after the day on which the waivers are granted.
(d) If the waivers requested under Subsection (1)(d) are granted, the Medicaid program shall begin providing dental services to the population described in Subsection (2)(b)(iii) within 90 days after the day on which the waivers are granted.
(4) If the federal share of the cost of providing dental services under this section will be less than 55% during any portion of the next fiscal year, the Medicaid program shall cease providing dental services under this section no later than the end of the current fiscal year.

Amended by Chapter 304, 2023 General Session
Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-209 Medicaid long-term support services housing coordinator.
(1) There is created within the Medicaid program a full-time-equivalent position of Medicaid long-term support services housing coordinator.
(2) The coordinator shall help Medicaid recipients receive long-term support services in a home or other community-based setting rather than in a nursing home or other institutional setting by:
(a) working with municipalities, counties, the Housing and Community Development Division within the Department of Workforce Services, and others to identify community-based settings available to recipients;
(b) working with the same entities to promote the development, construction, and availability of additional community-based settings;
(c) training Medicaid case managers and support coordinators on how to help Medicaid recipients move from an institutional setting to a community-based setting; and
(d) performing other related duties.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-210 Medicaid waiver expansion.
(1) As used in this section:
(a) "Federal poverty level" means the same as that term is defined in Section 26B-3-207.

(b) "Medicaid waiver expansion" means an expansion of the Medicaid program in accordance with this section.

(2)

(a) Before January 1, 2019, the department shall apply to CMS for approval of a waiver or state plan amendment to implement the Medicaid waiver expansion.

(b) The Medicaid waiver expansion shall:

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

(ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for enrolling an individual in the Medicaid program;

(iii) provide Medicaid benefits through the state's Medicaid accountable care organizations in areas where a Medicaid accountable care organization is implemented;

(iv) integrate the delivery of behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model;

(v) include a path to self-sufficiency, including work activities as defined in 42 U.S.C. Sec. 607(d), for qualified adults;

(vi) require an individual who is offered a private health benefit plan by an employer to enroll in the employer's health plan;

(vii) sunset in accordance with Subsection (5)(a); and

(viii) permit the state to close enrollment in the Medicaid waiver expansion if the department has insufficient funding to provide services to additional eligible individuals.

(3) If the Medicaid waiver described in Subsection (2)(a) is approved, the department may only pay the state portion of costs for the Medicaid waiver expansion with appropriations from:

(a) the Medicaid ACA Fund, created in Section 26B-1-315;

(b) county contributions to the non-federal share of Medicaid expenditures; and

(c) any other contributions, funds, or transfers from a non-state agency for Medicaid expenditures.

(4)

(a) In consultation with the department, Medicaid accountable care organizations and counties that elect to integrate care under Subsection (2)(b)(iv) shall collaborate on enrollment, engagement of patients, and coordination of services.

(b) As part of the provision described in Subsection (2)(b)(iv), the department shall apply for a waiver to permit the creation of an integrated delivery system:

(i) for any geographic area that expresses interest in integrating the delivery of services under Subsection (2)(b)(iv); and

(ii) in which the department:

(A) may permit a local mental health authority to integrate the delivery of behavioral health services and physical health services;

(B) may permit a county, local mental health authority, or Medicaid accountable care organization to integrate the delivery of behavioral health services and physical health services to select groups within the population that are newly eligible under the Medicaid waiver expansion; and

(C) may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to integrate payments for behavioral health services and physical health services to plans or providers.

(5)

(a) If federal financial participation for the Medicaid waiver expansion is reduced below 90%, the authority of the department to implement the Medicaid waiver expansion shall sunset no later than the next July 1 after the date on which the federal financial participation is reduced.
(b) The department shall close the program to new enrollment if the cost of the Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are authorized by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.

Amended by Chapter 250, 2024 General Session
Amended by Chapter 439, 2024 General Session

26B-3-211 Primary Care Network enhancement waiver program.

(1) As used in this section:
(a) "Enhancement waiver program" means the Primary Care Network enhancement waiver program described in this section.
(b) "Federal poverty level" means the poverty guidelines established by the secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec. 9902(2).
(c) "Health coverage improvement program" means the same as that term is defined in Section 26B-3-207.
(d) "Income eligibility ceiling" means the percentage of federal poverty level:
(i) established by the Legislature in an appropriations act adopted pursuant to Title 63J, Chapter 1, Budgetary Procedures Act; and
(ii) under which an individual may qualify for coverage in the enhancement waiver program in accordance with this section.
(e) "Optional population" means the optional expansion population under PPACA if the expansion provides coverage for individuals at or above 95% of the federal poverty level.
(f) "Primary Care Network" means the state Primary Care Network program created by the Medicaid primary care network demonstration waiver obtained under Section 26B-3-108.
(2) The department shall continue to implement the Primary Care Network program for qualified individuals under the Primary Care Network program.
(3)
(a) The division shall apply for a Medicaid waiver or a state plan amendment with CMS to implement, within the state Medicaid program, the enhancement waiver program described in this section within six months after the day on which:
(i) the division receives a notice from CMS that the waiver for the Medicaid waiver expansion submitted under Section 26B-3-210, Medicaid waiver expansion, will not be approved; or
(ii) the division withdraws the waiver for the Medicaid waiver expansion submitted under Section 26B-3-210, Medicaid waiver expansion.
(b) The division may not apply for a waiver under Subsection (3)(a) while a waiver request under Section 26B-3-210, Medicaid waiver expansion, is pending with CMS.
(4) An individual who is eligible for the enhancement waiver program may receive the following benefits under the enhancement waiver program:
(a) the benefits offered under the Primary Care Network program;
(b) diagnostic testing and procedures;
(c) medical specialty care;
(d) inpatient hospital services;
(e) outpatient hospital services;
(f) outpatient behavioral health care, including outpatient substance use care; and

(g) for an individual who qualifies for the health coverage improvement program, as approved by CMS, temporary residential treatment for substance use in a short term, non-institutional, 24-hour facility, without a bed capacity limit, that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan.

(5) An individual is eligible for the enhancement waiver program if, at the time of enrollment:

(a) the individual is qualified to enroll in the Primary Care Network or the health coverage improvement program;

(b) the individual's annual income is below the income eligibility ceiling established by the Legislature under Subsection (1)(d); and

(c) the individual meets the eligibility criteria established by the department under Subsection (6).

(6)

(a) Based on available funding and approval from CMS, the department shall determine the criteria for an individual to qualify for the enhancement waiver program, based on the following priority:

(i) adults in the expansion population, as defined in Section 26B-3-207, who qualify for the health coverage improvement program;

(ii) adults with dependent children who qualify for the health coverage improvement program under Subsection 26B-3-207(3) ;

(iii) adults with dependent children who do not qualify for the health coverage improvement program; and

(iv) if funding is available, adults without dependent children.

(b) The number of individuals enrolled in the enhancement waiver program may not exceed 105% of the number of individuals who were enrolled in the Primary Care Network on December 31, 2017.

(c) The department may only use appropriations from the Medicaid ACA Fund created in Section 26B-1-315 to fund the state portion of the enhancement waiver program.

(7) The department may request a modification of the income eligibility ceiling and the eligibility criteria under Subsection (6) from CMS each fiscal year based on enrollment in the enhancement waiver program, projected enrollment in the enhancement waiver program, costs to the state, and the state budget.

(8) The department may implement the enhancement waiver program by contracting with Medicaid accountable care organizations to administer the enhancement waiver program.

(9) In accordance with Subsections 26B-3-207(10) and (11), the department may use funds that have been appropriated for the health coverage improvement program to implement the enhancement waiver program.

(10) If the department expands the state Medicaid program to the optional population, the department:

(a) except as provided in Subsection (11), may not accept any new enrollees into the enhancement waiver program after the day on which the expansion to the optional population is effective;

(b) shall suspend the enhancement waiver program within one year after the day on which the expansion to the optional population is effective; and

(c) shall work with CMS to maintain the waiver for the enhancement waiver program submitted under Subsection (3) while the enhancement waiver program is suspended under Subsection (10)(b).

(11) If, after the expansion to the optional population described in Subsection (10) takes effect, the expansion to the optional population is repealed by either the state or the federal government, the department shall reinstate the enhancement waiver program and continue to accept new

enrollees into the enhancement waiver program in accordance with the provisions of this section.

Amended by Chapter 439, 2024 General Session

26B-3-212 Limited family planning services for low-income individuals.

(1) As used in this section:

(a)

(i) "Family planning services" means family planning services that are provided under the state Medicaid program, including:

(A) sexual health education and family planning counseling; and

(B) other medical diagnosis, treatment, or preventative care routinely provided as part of a family planning service visit.

(ii) "Family planning services" do not include an abortion, as that term is defined in Section 76-7-301 or 76-7a-101.

(b) "Low-income individual" means an individual who:

(i) has an income level that is equal to or below 185% of the federal poverty level; and

(ii) does not qualify for full coverage under the Medicaid program.

(2) Before January 1, 2024, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to:

(a) offer a program that provides family planning services to low-income individuals; and

(b) receive a federal match rate of 90% of state expenditures for family planning services provided under the waiver or state plan amendment.

Amended by Chapter 240, 2024 General Session

26B-3-213 Medicaid waiver for mental health crisis lines and mobile crisis outreach teams.

(1) As used in this section:

(a) "Local mental health crisis line" means the same as that term is defined in Section 26B-5-610.

(b) "Mental health crisis" means:

(i) a mental health condition that manifests itself in an individual by symptoms of sufficient severity that a prudent layperson who possesses an average knowledge of mental health issues could reasonably expect the absence of immediate attention or intervention to result in:

(A) serious danger to the individual's health or well-being; or

(B) a danger to the health or well-being of others; or

(ii) a mental health condition that, in the opinion of a mental health therapist or the therapist's designee, requires direct professional observation or the intervention of a mental health therapist.

(c)

(i) "Mental health crisis services" means direct mental health services and on-site intervention that a mobile crisis outreach team provides to an individual suffering from a mental health crisis, including the provision of safety and care plans, prolonged mental health services for up to 90 days, and referrals to other community resources.

(ii) "Mental health crisis services" includes:

(A) local mental health crisis lines; and

(B) the statewide mental health crisis line.

(d) "Mental health therapist" means the same as that term is defined in Section 58-60-102.

(e) "Mobile crisis outreach team" or "MCOT" means a mobile team of medical and mental health professionals that, in coordination with local law enforcement and emergency medical service personnel, provides mental health crisis services.
(f) "Statewide mental health crisis line" means the same as that term is defined in Section 26B-5-610.
(2) In consultation with the Behavioral Health Crisis Response Committee created in Section 63C-18-202, the department shall develop a proposal to amend the state Medicaid plan to include mental health crisis services, including the statewide mental health crisis line, local mental health crisis lines, and mobile crisis outreach teams.
(3) By January 1, 2019, the department shall apply for a Medicaid waiver with CMS, if necessary to implement, within the state Medicaid program, the mental health crisis services described in Subsection (2).

Amended by Chapter 245, 2024 General Session

26B-3-214 Medicaid waiver for coverage of mental health services in schools.
(1) As used in this section, "local education agency" means:
(a) a school district;
(b) a charter school; or
(c) the Utah Schools for the Deaf and the Blind.
(2) In consultation with the State Board of Education, the department shall develop a proposal to allow the state Medicaid program to reimburse a local education agency, a local mental health authority, or a private provider for covered mental health services provided:
(a) in accordance with Section 53E-9-203; and
(b)
(i) at a local education agency building or facility; or
(ii) by an employee or contractor of a local education agency.
(3) Before January 1, 2020, the department shall apply to CMS for a state plan amendment to implement the coverage described in Subsection (2).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-215 Coverage for in vitro fertilization and genetic testing.
(1) As used in this section:
(a) "Qualified condition" means:
(i) cystic fibrosis;
(ii) spinal muscular atrophy;
(iii) Morquio Syndrome;
(iv) myotonic dystrophy; or
(v) sickle cell anemia.
(b) "Qualified enrollee" means an individual who:
(i) is enrolled in the Medicaid program;
(ii) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and
(iii) intends to get pregnant with a partner who is diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual.
(2) Before January 1, 2021, the department shall apply for a Medicaid waiver or a state plan amendment with the Centers for Medicare and Medicaid Services within the United States

Department of Health and Human Services to implement the coverage described in Subsection (3).

(3) If the waiver described in Subsection (2) is approved, the Medicaid program shall provide coverage to a qualified enrollee for:
  (a) in vitro fertilization services; and
  (b) genetic testing of a qualified enrollee who receives in vitro fertilization services under Subsection (3)(a).
(4) The Medicaid program may not provide the coverage described in Subsection (3) before the later of:
  (a) the day on which the waiver described in Subsection (2) is approved; and
  (b) January 1, 2021.
(5) Before November 1, 2022, and before November 1 of every third year thereafter, the department shall:
  (a) calculate the change in state spending attributable to the coverage under this section; and
  (b) report the amount described in Subsection (5)(a) to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-216 Medicaid waiver for fertility preservation services.

(1) As used in this section:
  (a) "Iatrogenic infertility" means an impairment of fertility or reproductive functioning caused by surgery, chemotherapy, radiation, or other medical treatment.
  (b) "Physician" means an individual licensed to practice under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
  (c) "Qualified enrollee" means an individual who:
    (i) is enrolled in the Medicaid program;
    (ii) has been diagnosed with a form of cancer by a physician; and
    (iii) needs treatment for that cancer that may cause a substantial risk of sterility or iatrogenic infertility, including surgery, radiation, or chemotherapy.
  (d) "Standard fertility preservation service" means a fertility preservation procedure and service that:
    (i) is not considered experimental or investigational by the American Society for Reproductive Medicine or the American Society of Clinical Oncology; and
    (ii) is consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, including:
      (A) sperm banking;
      (B) oocyte banking;
      (C) embryo banking;
      (D) banking of reproductive tissues; and
      (E) storage of reproductive cells and tissues.
(2) Before January 1, 2022, the department shall apply for a Medicaid waiver or a state plan amendment with CMS to implement the coverage described in Subsection (3).
(3) If the waiver or state plan amendment described in Subsection (2) is approved, the Medicaid program shall provide coverage to a qualified enrollee for standard fertility preservation services.

(4) The Medicaid program may not provide the coverage described in Subsection (3) before the later of:
(a) the day on which the waiver described in Subsection (2) is approved; and
(b) January 1, 2023.
(5) Before November 1, 2023, and before November 1 of each third year after 2023, the department shall:
(a) calculate the change in state spending attributable to the coverage described in this section; and
(b) report the amount described in Subsection (5)(a) to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-217 Medicaid waiver for coverage of qualified inmates leaving prison or jail.
(1) As used in this section:
(a) "Correctional facility" means:
(i) a county jail;
(ii) a prison, penitentiary, or other institution operated by or under contract with the Department of Corrections for the confinement of an offender, as defined in Section 64-13-1; or
(iii) a facility for secure confinement of minors operated by the Division of Juvenile Justice and Youth Services.
(b) "Limited Medicaid benefit" means:
(i) reentry case management services;
(ii) physical and behavioral health clinical services;
(iii) medications and medication administration;
(iv) medication-assisted treatment, including all United States Food and Drug Administration approved medications, including coverage for counseling; and
(v) other services as determined by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(c) "Qualified inmate" means an individual who:
(i) is incarcerated in a correctional facility; and
(ii) is ineligible for Medicaid as a result of incarceration but would otherwise qualify for Medicaid.
(2) Subject to appropriation, before July 1, 2024, the division shall apply for a Medicaid waiver, or amend an existing Medicaid waiver application, with CMS to offer a program to provide a limited Medicaid benefit to a qualified inmate for up to 90 days immediately before the day on which the qualified inmate is released from a correctional facility.
(3)
(a) Savings to state and local funds that result from the use of federal funds provided under this section shall be used in accordance with a reinvestment plan as mandated by CMS.
(b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules for a participating county to establish a reinvestment plan described in Subsection (3)(a).
(4) If the waiver or amended waiver described in Subsection (2) is approved, the department shall report to the Health and Human Services Interim Committee each year before November 30 while the waiver is in effect regarding:
(a) the number of qualified inmates served under the program;
(b) the cost of the program; and
(c) the effectiveness of the program, including:

(i) any reduction in the number of emergency room visits or hospitalizations by inmates after release from a correctional facility;
(ii) any reduction in the number of inmates undergoing inpatient treatment after release from a correctional facility;
(iii) any reduction in overdose rates and deaths of inmates after release from a correctional facility; and
(iv) any other costs or benefits as a result of the program.
(5) Before July 1, 2024, the department shall amend the Medicaid waiver related to housing support services to include an individual that was a qualified inmate within the previous 12 months.
(6) The department may elect to not apply for a Medicaid waiver or limit services described in this section based on appropriation.

Amended by Chapter 284, 2024 General Session

26B-3-218 Medicaid waiver for inpatient care in an institution for mental diseases.
(1) As used in this section, "institution for mental diseases" means the same as that term is defined in 42 C.F.R. Sec. 435.1010.
(2) Before August 1, 2020, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to offer a program that provides reimbursement for mental health services that are provided:
(a) in an institution for mental diseases that includes more than 16 beds; and
(b) to an individual who receives mental health services in an institution for mental diseases for a period of more than 15 days in a calendar month.
(3) If the waiver or state plan amendment described in Subsection (2) is approved, the department shalldevelop and offer the program described in Subsection (2).
(4) Notwithstanding Sections 17-43-201 and 17-43-301, if the waiver or state plan amendment described in Subsection (2) is approved, a county does not have to provide matching funds to the state for the mental health services described in Subsection (2) that are provided to an individual who qualifies for Medicaid coverage under Section 26B-3-113 or 26B-3-207.

Amended by Chapter 250, 2024 General Session

26B-3-219 Reimbursement for crisis management services provided in a behavioral health receiving center -- Integration of payment for physical health services.
(1) As used in this section:
(a) "Accountable care organization" means the same as that term is defined in Section 26B-3-204.
(b) "Behavioral health receiving center" means the same as that term is defined in Section 26B-4-114.
(c) "Crisis management services" means behavioral health services provided to an individual who is experiencing a mental health crisis.
(d) "Managed care organization" means the same as that term is defined in 42 C.F.R. Sec. 438.2.
(2) Before July 1, 2020, the division shall apply for a Medicaid waiver or state plan amendment with CMS to offer a program that provides reimbursement through a bundled daily rate for crisis management services that are delivered to an individual during the individual's stay at a behavioral health receiving center.

(3) If the waiver or state plan amendment described in Subsection (2) is approved, the department shall:
(a) implement the program described in Subsection (2); and
(b) require a managed care organization that contracts with the state's Medicaid program for behavioral health services or integrated health services to provide coverage for crisis management services that are delivered to an individual during the individual's stay at a behavioral health receiving center.
(4)
(a) The department may elect to integrate payment for physical health services provided in a behavioral health receiving center.
(b) In determining whether to integrate payment under Subsection (4)(a), the department shall consult with accountable care organizations and counties in the state.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-220 Crisis services -- Reimbursement.

The department shall submit a waiver or state plan amendment to allow for reimbursement for 988 services provided to an individual who is eligible and enrolled in Medicaid at the time this service is provided.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-221 Medicaid waiver for respite care facility that provides services to homeless individuals.

(1) As used in this section:
(a) "Adult in the expansion population" means an adult:
(i) described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and
(ii) not otherwise eligible for Medicaid as a mandatory categorically needy individual.
(b) "Homeless" means the same as that term is defined in Section 26B-3-207.
(c) "Medical respite care" means short-term housing with supportive medical services.
(d) "Medical respite facility" means a residential facility that provides medical respite care to homeless individuals.
(2) Before January 1, 2025, the department shall amend a Medicaid waiver with CMS to choose no more than two medical respite facilities to reimburse for services provided to an individual who is:
(a) homeless; and
(b) an adult in the expansion population.
(3) The department shall choose medical respite facilities that are best able to serve homeless individuals who are adults in the expansion population.
(4) If the waiver or state plan amendment described in Subsection (2) is approved, while the waiver or state plan amendment is in effect, the department shall submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:
(a) the number of homeless individuals served under the waiver;
(b) the cost of the program; and
(c) the reduction of health care costs due to the program's implementation.
(5) Through administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall further define and limit the services, described in this section, provided to a homeless individual.

Amended by Chapter 284, 2024 General Session

26B-3-222 Medicaid waiver expansion for extraordinary care reimbursement.

(1) As used in this section:

(a) "Existing home and community-based services waiver" means an existing home and community-based services waiver in the state that serves an individual:

(i) with an acquired brain injury;

(ii) with an intellectual or physical disability; or

(iii) who is 65 years old or older.

(b) "Guardian" means a person appointed by a court to manage the affairs of a living individual.

(c) "Parent" means a biological parent, adoptive parent, or step-parent of an individual.

(d) "Personal care services" means a service that:

(i) is furnished to an individual who is not an inpatient nor a resident of a hospital, nursing facility, intermediate care facility, or institution for mental diseases;

(ii) is authorized for an individual described in Subsection (1)(d)(i) in accordance with a plan of treatment;

(iii) is provided by an individual who is qualified to provide the services; and

(iv) is furnished in a home or another community-based setting.

(e) "Waiver enrollee" means an individual who is enrolled in an existing home and community-based services waiver.

(2) Before July 1, 2021, the department shall apply with CMS for an amendment to an existing home and community-based services waiver to implement a program to offer reimbursement to an individual who provides personal care services that constitute extraordinary care to a waiver enrollee who is the individual's spouse.

(3) If CMS approves the amendment described in Subsection (2), the department shall implement the program described in Subsection (2).

(4) The department shall by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define "extraordinary care" for purposes of Subsection (2).

(5) Before July 1, 2023, the department shall apply with CMS for an amendment to an existing home and community-based services waiver to implement a program to offer reimbursement to an individual who provides personal care services that constitute extraordinary care to a waiver enrollee to whom the individual is a parent or guardian.

(6) If CMS approves the amendment described in Subsection (5), the department shall implement the program described in Subsection (5).

(7) The department shall by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define "extraordinary care" for purposes of Subsection (5).

Amended by Chapter 247, 2024 General Session

26B-3-223 Delivery system adjustments for the targeted adult Medicaid program.

(1) As used in this section, "targeted adult Medicaid program" means the same as that term is defined in Section 26B-3-207.

(2) The department may implement the delivery system adjustments authorized under Subsection (3) only on the later of:

(a) July 1, 2023; and

(b) the department determining that the Medicaid program, including providers and managed care organizations, are satisfying the metrics established in collaboration with the Behavioral Health Delivery Working Group.

(3) The department may, for individuals who are enrolled in the targeted adult Medicaid program:
(a) integrate the delivery of behavioral and physical health in certain counties; and
(b) deliver behavioral health services through an accountable care organization where implemented.

(4) Before implementing the delivery system adjustments described in Subsection (3) in a county, the department shall, at a minimum, seek input from:
(a) individuals who qualify for the targeted adult Medicaid program who reside in the county;
(b) the county's executive officer, legislative body, and other county officials who are involved in the delivery of behavioral health services;
(c) the local mental health authority and local substance abuse authority that serves the county;
(d) Medicaid managed care organizations operating in the state, including Medicaid accountable care organizations;
(e) providers of physical or behavioral health services in the county who provide services to enrollees in the targeted adult Medicaid program in the county; and
(f) other individuals that the department deems necessary.

(5) If the department provides Medicaid coverage through a managed care delivery system under this section, the department shall include language in the department's managed care contracts that require the managed care plan to:
(a) be in compliance with federal Medicaid managed care requirements;
(b) timely and accurately process authorizations and claims in accordance with Medicaid policy and contract requirements;
(c) adequately reimburse providers to maintain adequacy of access to care;
(d) provide care management services sufficient to meet the needs of Medicaid eligible individuals enrolled in the managed care plan's plan; and
(e) timely resolve any disputes between a provider or enrollee with the managed care plan.

(6) The department may take corrective action if the managed care organization fails to comply with the terms of the managed care organization's contract.

Amended by Chapter 245, 2024 General Session
Amended by Chapter 395, 2024 General Session

26B-3-224 Medicaid waiver for increased integrated health care reimbursement.

(1) As used in this section:
(a) "Integrated health care setting" means a health care or behavioral health care setting that provides integrated physical and behavioral health care services.
(b) "Local mental health authority" means a local mental health authority described in Section 17-43-301.

(2) The department shall develop a proposal to allow the state Medicaid program to reimburse a local mental health authority for covered physical health care services provided in an integrated health care setting to Medicaid eligible individuals.

(3) The department shall apply for a Medicaid waiver or a state plan amendment with CMS to implement the proposal described in Subsection (2).

(4) If the waiver or state plan amendment described in Subsection (3) is approved, the department shall:
(a) implement the proposal described in Subsection (2); and

(b) while the waiver or state plan amendment is in effect, submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:
(i) the number of patients served under the waiver or state plan amendment;
(ii) the cost of the waiver or state plan amendment; and
(iii) any benefits of the waiver or state plan amendment.

Amended by Chapter 284, 2024 General Session

26B-3-225 Coverage for autism spectrum disorder.

(1) As used in this section:
(a)
(i) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
(ii) "Applied behavior analysis" includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
(b) "Autism spectrum disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.
(c) "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:
(i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
(ii) provided or supervised by:
(A) a board certified behavior analyst; or
(B) an individual licensed under Title 58, Occupations and Professions, whose scope of practice includes mental health services.
(d) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests:
(i) performed by:
(A) a licensed physician who is board certified in neurology, psychiatry, or pediatrics and has experience diagnosing autism spectrum disorder; or
(B) a licensed psychologist with experience diagnosing autism spectrum disorder; and
(ii) necessary to diagnose whether an individual has an autism spectrum disorder.
(e) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.
(f) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(g) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(h) "Therapeutic care" means services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.
(i)
(i) "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an enrollee diagnosed with an autism spectrum disorder by a physician or a licensed psychologist described in Subsection (1)(d) who determines the care to be medically necessary.
(ii) "Treatment for autism spectrum disorder" includes:

(A) behavioral health treatment, provided or supervised by a person described in Subsection (1)(c)(ii);
(B) pharmacy care;
(C) psychiatric care;
(D) psychological care; and
(E) therapeutic care.

(2) The department shall request a state plan amendment with CMS to provide treatment for autism spectrum disorder for an enrollee diagnosed with autism spectrum disorder.

Enacted by Chapter 326, 2023 General Session

26B-3-226 Medicaid waiver for rural healthcare for chronic conditions.

(1) As used in this section:
(a) "Qualified condition" means:
(i) diabetes;
(ii) high blood pressure;
(iii) congestive heart failure;
(iv) asthma;
(v) obesity;
(vi) chronic obstructive pulmonary disease; or
(vii) chronic kidney disease.
(b) "Qualified enrollee" means an individual who:
(i) is enrolled in the Medicaid program;
(ii) has been diagnosed as having a qualified condition; and
(iii) is not enrolled in an accountable care organization.

(2) Before January 1, 2024, the department shall apply for a Medicaid waiver with CMS to implement the coverage described in Subsection (3) for a three-year pilot program.

(3) If the waiver described in Subsection (2) is approved, the Medicaid program shall contract with a single entity to provide coordinated care for the following services to each qualified enrollee:
(a) a telemedicine platform for the qualified enrollee to use;
(b) an in-home initial visit to the qualified enrollee;
(c) daily remote monitoring of the qualified enrollee's qualified condition;
(d) all services in the qualified enrollee's language of choice;
(e) individual peer monitoring and coaching for the qualified enrollee;
(f) available access for the qualified enrollee to video-enabled consults and voice-enabled consults 24 hours a day, seven days a week;
(g) in-home biometric monitoring devices to monitor the qualified enrollee's qualified condition; and
(h) at-home medication delivery to the qualified enrollee.

(4) The Medicaid program may not provide the coverage described in Subsection (3) until the waiver is approved.

(5) Each year the waiver is active, the department shall submit a report to the Health and Human Services Interim Committee before November 30 detailing:
(a) the number of patients served under the waiver;
(b) the cost of the waiver; and
(c) any benefits of the waiver, including an estimate of:
(i) the reductions in emergency room visits or hospitalizations;
(ii) the reductions in 30-day hospital readmissions for the same diagnosis;

(iii) the reductions in complications related to qualified conditions; and
(iv) any improvements in health outcomes from baseline assessments.

Amended by Chapter 284, 2024 General Session

26B-3-227 Recreational therapy -- Reimbursement.

(1) As used in this section:
(a) "Assisted living facility" means the same as that term is defined in Section 26B-2-201.
(b) "Behavioral health program" means a behavioral health program described in Title 62A, Chapter 15, Substance Abuse and Mental Health Act.
(c) "General acute hospital" means the same as that term is defined in Section 26B-2-201.
(d) "Intermediate care facility" means the same as that term is defined in Section 58-15-101.
(e) "Mental health therapist" means the same as that term is defined in Section 58-60-102.
(f) "Qualified enrollee" means an individual who:
(i) is enrolled in the Medicaid program; and
(ii) has been referred for recreational therapy services by a mental health therapist.
(g) "Recreational therapy services" means the same as that term is defined in Section 58-40-102.
(h) "Skilled nursing facility" means the same as that term is defined in Section 58-15-101.
(i) "Youth residential treatment facility" means a facility that provides a 24-hour group living environment for four or more individuals who are under 18 years old and who are unrelated to the owner or provider of the facility.
(2) Before January 1, 2024, the department shall apply for a Medicaid waiver or a state plan with CMS to allow for reimbursement for recreational therapy services provided:
(a) to a qualified enrollee;
(b) by an individual authorized to engage in the practice of recreational therapy under Title 58, Chapter 40, Recreational Therapy Practice Act; and
(c) at a:
(i) general acute hospital;
(ii) youth residential treatment facility;
(iii) behavioral health program;
(iv) intermediate care facility;
(v) assisted living facility;
(vi) skilled nursing facility;
(vii) psychiatric hospital; or
(viii) mental health agency.
(3) If the waiver or state plan amendment described in Subsection (2) is approved, the Medicaid program shall provide coverage to a qualified enrollee for recreational therapy services.

Enacted by Chapter 288, 2023 General Session

26B-3-228 Medicaid coverage for certain postpartum women.

(1) As used in this section:
(a) "Extended postpartum period" means the period after a woman's pregnancy ends:
(i) beginning the day after the initial postpartum period; and
(ii) ending on the last day of the month that is 12 months after the day on which the woman's pregnancy ends.
(b) "Initial postpartum period" means the period:
(i) beginning on the day on which a woman's pregnancy ends; and

(ii) ending on the last day of the month that is 60 days after the day on which the woman's pregnancy ends.

(c) "Miscarriage" means the spontaneous or accidental loss of a fetus, regardless of gestational age or the duration of the pregnancy.

(2) Before July 1, 2023, the division shall request a waiver or state plan amendment to, in accordance with 42 U.S.C. Sec. 1396a(e)(16), provide continuous Medicaid coverage during the woman's extended postpartum period if:

(a) the woman is eligible for Medicaid during the woman's pregnancy; and

(b) the woman's pregnancy ended by way of:

(i) birth;

(ii) miscarriage;

(iii) stillbirth; or

(iv) an abortion that is permitted under Section 76-7a-201.

(3) If the request described in Subsection (2) is denied or is not approved by January 1, 2024, the division shall request a waiver or state plan amendment to, in accordance with 42 U.S.C. Sec. 1396a(e)(16), provide continuous Medicaid coverage during the woman's extended postpartum period if the woman is eligible for Medicaid during the woman's pregnancy.

Enacted by Chapter 316, 2023 General Session

26B-3-230 Traditional healing services waiver.

(1) As used in this section:

(a) "Eligible facility" means any of the following:

(i) an Indian Health Service facility;

(ii) a tribal health program designated under the Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638;

(iii) an urban Indian organization as that term is defined in 25 U.S.C. Sec. 1603; or

(iv) a facility operated by a person that contracts with an organization described in Subsection (1)(a)(iii).

(b) "Traditional healing provider" means an individual who provides traditional healing services in a manner that is recognized by an American Indian or Alaskan Native tribe as being consistent with the tribe's traditional healing practices.

(c) "Traditional healing services" means a system of culturally appropriate healing methods for physical, mental, and emotional healing.

(2) On or before January 1, 2025, the department shall apply for a Medicaid waiver to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to an enrollee who is a member of an American Indian or Alaskan Native tribe.

(3) A service under this section may not be reimbursed if:

(a) the traditional healing provider is restricted from providing the service;

(b) the service is contraindicated by a medical provider due to the potential to cause harm; or

(c) the service is not part of the patient's plan of care.

(4) The department may further define and limit services described in this section.

Enacted by Chapter 239, 2024 General Session