Effective 5/3/2023

Chapter 3
Health Care - Administration and Assistance

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

Part 2
Medicaid Waivers

26B-3-201 Medicaid waiver for 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.
(3) Before July 1, 2006, the division shall submit a state Medicaid Plan amendment to CMS to provide medical coverage for independent foster care adolescents effective fiscal year 2006-07.

Renumbered and Amended by Chapter 306, 2023 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.

(1) As used in this section:

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

(i) physical health services; or

(ii) integrated physical and behavioral health services.

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

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

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

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

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

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

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

(3) If the General Fund growth factor is greater than or equal to 100%, but less than 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs and

behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by the General Fund growth factor.

(4) If the General Fund growth factor is greater than or equal to 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health plans is greater than or equal to the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by 102% and less than or equal to the current fiscal year PMPM for the ACOs and behavioral health plans multiplied by the General Fund growth factor.

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

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

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

Renumbered and Amended by Chapter 306, 2023 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) No later than July 1, 2014, the department shall seek federal approval of a state plan amendment that creates a qualified long-term care insurance partnership.
(3) The department may make rules to comply with federal laws and regulations relating to qualified long-term care insurance partnerships and qualified long-term care insurance contracts.

Renumbered and Amended by Chapter 306, 2023 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 Expansion 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.

(6) If the Medicaid waiver expansion is approved by CMS, the department shall report to the Social Services Appropriations Subcommittee on or before November 1 of each year that the Medicaid waiver expansion is operational:
(a) the number of individuals who enrolled in the Medicaid waiver program;
(b) costs to the state for the Medicaid waiver program;
(c) estimated costs for the current and following state fiscal year; and
(d) recommendations to control costs of the Medicaid waiver expansion.

Renumbered and Amended by Chapter 306, 2023 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 Expansion 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.

Renumbered and Amended by Chapter 306, 2023 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.
(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.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 316, 2023 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 Commission created in Section 63C-18-202, the department shall develop a proposal to amend the state Medicaid plan to include mental health crisis services, including the statewide mental health crisis line, local mental health crisis lines, and mobile crisis outreach teams.

(3) By January 1, 2019, the department shall apply for a Medicaid waiver with CMS, if necessary to implement, within the state Medicaid program, the mental health crisis services described in Subsection (2).

Renumbered and Amended by Chapter 306, 2023 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) the Department of Corrections, created in Section 64-13-2; or
    (iii) a prison, penitentiary, or other institution operated by or under contract with the Department of Corrections for the confinement of an offender, as defined in Section 64-13-1.
  (b) "Qualified inmate" means an individual who:
    (i) is incarcerated in a correctional facility; and
    (ii) has:
      (A) a chronic physical or behavioral health condition;
      (B) a mental illness, as defined in Section 26B-5-301; or
      (C) an opioid use disorder.
(2) Before July 1, 2020, the division shall apply for a Medicaid waiver or a state plan amendment with CMS to offer a program to provide Medicaid coverage to a qualified inmate for up to 30 days immediately before the day on which the qualified inmate is released from a correctional facility.
(3) If the waiver or state plan amendment described in Subsection (2) is approved, the department shall report to the Health and Human Services Interim Committee each year before November 30 while the waiver or state plan amendment is in effect regarding:
  (a) the number of qualified inmates served under the program;
  (b) the cost of the program; and
  (c) the effectiveness of the program, including:
    (i) any reduction in the number of emergency room visits or hospitalizations by inmates after release from a correctional facility;
    (ii) any reduction in the number of inmates undergoing inpatient treatment after release from a correctional facility;
    (iii) any reduction in overdose rates and deaths of inmates after release from a correctional facility; and
    (iv) any other costs or benefits as a result of the program.
(4) If the waiver or state plan amendment described in Subsection (2) is approved, a county that is responsible for the cost of a qualified inmate's medical care shall provide the required matching funds to the state for:
  (a) any costs to enroll the qualified inmate for the Medicaid coverage described in Subsection (2);
  (b) any administrative fees for the Medicaid coverage described in Subsection (2); and
  (c) the Medicaid coverage that is provided to the qualified inmate under Subsection (2).

Renumbered and Amended by Chapter 306, 2023 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 shall:
(a) develop and offer the program described in Subsection (2); and
(b) submit to the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee any report that the department submits to CMS that relates to the budget neutrality, independent waiver evaluation, or performance metrics of the program described in Subsection (2), within 15 days after the day on which the report is submitted to CMS.
(4) Notwithstanding Sections 17-43-201 and 17-43-301, if the waiver or state plan amendment described in Subsection (2) is approved, a county does not have to provide matching funds to the state for the mental health services described in Subsection (2) that are provided to an individual who qualifies for Medicaid coverage under Section 26B-3-113 or 26B-3-207.

Renumbered and Amended by Chapter 306, 2023 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, 2022, the department shall apply for a Medicaid waiver or state plan amendment with CMS to choose a single medical respite facility to reimburse for services provided to an individual who is:
(a) homeless; and
(b) an adult in the expansion population.
(3) The department shall choose a medical respite facility best able to serve homeless individuals who are adults in the expansion population.
(4) If the waiver or state plan amendment described in Subsection (2) is approved, while the waiver or state plan amendment is in effect, the department shall submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:
(a) the number of homeless individuals served at the facility;
(b) the cost of the program; and
(c) the reduction of health care costs due to the program's implementation.
(5) Through administrative rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall further define and limit the services, described in this section, provided to a homeless individual.

Renumbered and Amended by Chapter 306, 2023 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 or adoptive 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).

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 315, 2023 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 working group convened under Subsection 26B-3-138(2).
(3) The department may, for individuals who are enrolled in the targeted adult Medicaid program:
(a) integrate the delivery of behavioral and physical health in certain counties; and
(b) deliver behavioral health services through an accountable care organization where implemented.
(4) Before implementing the delivery system adjustments described in Subsection (3) in a county, the department shall, at a minimum, seek input from:
(a) individuals who qualify for the targeted adult Medicaid program who reside in the county;
(b) the county's executive officer, legislative body, and other county officials who are involved in the delivery of behavioral health services;
(c) the local mental health authority and 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.

Renumbered and Amended by Chapter 306, 2023 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) Before December 31, 2022, the department shall apply for a Medicaid waiver or a state plan amendment with CMS to implement the proposal described in Subsection (2).
(4) If the waiver or state plan amendment described in Subsection (3) is approved, the department shall:
(a) implement the proposal described in Subsection (2); and
(b) while the waiver or state plan amendment is in effect, submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:
(i) the number of patients served under the waiver or state plan amendment;
(ii) the cost of the waiver or state plan amendment; and
(iii) any benefits of the waiver or state plan amendment.

Renumbered and Amended by Chapter 306, 2023 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 the Centers for Medicare and Medicaid Services 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.

Enacted by Chapter 336, 2023 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

Part 3
Administration of Medicaid Programs: Drug Utilization Review and Long Term Care Facility Certification

26B-3-301 Definitions.

As used in this part:

(1) "Appropriate and medically necessary" means, regarding drug prescribing, dispensing, and patient usage, that it is in conformity with the criteria and standards developed in accordance with this part.

(2) "Board" means the Drug Utilization Review Board created in Section 26B-3-302.

(3) "Certified program" means a nursing care facility program with Medicaid certification.

(4) "Compendia" means resources widely accepted by the medical profession in the efficacious use of drugs, including "American Hospital Formulary Service Drug Information," "U.S. Pharmacopeia - Drug Information," "A.M.A. Drug Evaluations," peer-reviewed medical literature, and information provided by manufacturers of drug products.

(5) "Counseling" means the activities conducted by a pharmacist to inform Medicaid recipients about the proper use of drugs, as required by the board under this part.

(6) "Criteria" means those predetermined and explicitly accepted elements used to measure drug use on an ongoing basis in order to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(7) "Drug-disease contraindications" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.

(8) "Drug-interactions" means that two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present, or that leads to interference with the effectiveness of one or any of the drugs.

(9) "Drug Utilization Review" or "DUR" means the program designed to measure and assess, on a retrospective and prospective basis, the proper use of outpatient drugs in the Medicaid program.

(10) "Intervention" means a form of communication utilized by the board with a prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

(11) "Medicaid certification" means the right of a nursing care facility, as a provider of a nursing care facility program, to receive Medicaid reimbursement for a specified number of beds within the facility.

(12)

(a) "Nursing care facility" means the following facilities licensed by the department under Chapter 2, Part 2, Health Care Facility Licensing and Inspection:

(i) skilled nursing facilities;

(ii) intermediate care facilities; and

(iii) an intermediate care facility for people with an intellectual disability.

(b) "Nursing care facility" does not mean a critical access hospital that meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2) (1998).

(13) "Nursing care facility program" means the personnel, licenses, services, contracts, and all other requirements that shall be met for a nursing care facility to be eligible for Medicaid certification under this part and division rule.
(14) "Overutilization" or "underutilization" means the use of a drug in such quantities that the desired therapeutic goal is not achieved.
(15) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act.
(16) "Physical facility" means the buildings or other physical structures where a nursing care facility program is operated.
(17) "Physician" means a person licensed in this state to practice medicine and surgery under Section 58-67-301 or osteopathic medicine under Section 58-68-301.
(18) "Prospective DUR" means that part of the drug utilization review program that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy problems based on explicit and predetermined criteria and standards.
(19) "Retrospective DUR" means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug use data against predetermined and explicit criteria and standards, on an ongoing basis with professional input.
(20) "Rural county" means a county with a population of less than 50,000, as determined by:
(a) the most recent official census or census estimate of the United States Bureau of the Census; or
(b) the most recent population estimate for the county from the Utah Population Committee, if a population figure for the county is not available under Subsection (20)(a).
(21) "Service area" means the boundaries of the distinct geographic area served by a certified program as determined by the division in accordance with this part and division rule.
(22) "Standards" means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the Medicaid recipient database.
(23) "SURS" means the Surveillance Utilization Review System of the Medicaid program.
(24) "Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.
(25) "Therapeutic duplication" means prescribing and dispensing the same drug or two or more drugs from the same therapeutic class where periods of drug administration overlap and where that practice is not medically indicated.
(26) "Urban county" means a county that is not a rural county.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-302 DUR Board -- Creation and membership -- Expenses.
(1) There is created a 12-member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.
(2)
(a) Except as required by Subsection (2)(b), as terms of current board members expire, the executive director shall appoint each new member or reappointed member to a four-year term.
(b) Notwithstanding the requirements of Subsection (2)(a), the executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(c) Persons appointed to the board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms.
(d) The executive director shall provide for geographic balance in representation on the board.
(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.
(4) The membership shall be comprised of the following:
(a) four physicians who are actively engaged in the practice of medicine or osteopathic medicine in this state, to be selected from a list of nominees provided by the Utah Medical Association;
(b) one physician in this state who is actively engaged in academic medicine;
(c) three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the Utah Pharmaceutical Association;
(d) one pharmacist who is actively engaged in academic pharmacy;
(e) one person who shall represent consumers;
(f) one person who shall represent pharmaceutical manufacturers, to be recommended by the Pharmaceutical Manufacturers Association; and
(g) one dentist licensed to practice in this state under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act, who is actively engaged in the practice of dentistry, nominated by the Utah Dental Association.
(5) Physician and pharmacist members of the board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.
(6) The board shall elect a chair from among its members who shall serve a one-year term, and may serve consecutive terms.
(7) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
(a) Section 63A-3-106;
(b) Section 63A-3-107; and
(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-303 DUR Board -- Responsibilities.

The board shall:
(1) develop rules necessary to carry out its responsibilities as defined in this part;
(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;
(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:
(a) therapeutic appropriateness;
(b) overutilization or underutilization;
(c) therapeutic duplication;
(d) drug-disease contraindications;
(e) drug-drug interactions;
(f) incorrect drug dosage or duration of drug treatment; and

(g) clinical abuse and misuse;
(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;
(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;
(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;
(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;
(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;
(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;
(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;
(11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec. 712;
(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;
(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63G, Chapter 4, Administrative Procedures Act;
(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:
(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;
(b) potential or actual severe or adverse reactions to drugs;
(c) therapeutic appropriateness;
(d) overutilization or underutilization;
(e) appropriate use of generics;
(f) therapeutic duplication;
(g) drug-disease contraindications;
(h) drug-drug interactions;
(i) incorrect drug dosage and duration of drug treatment;
(j) drug allergy interactions; and
(k) clinical abuse and misuse;
(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:
(a) the name and description of the medication;
(b) administration, form, and duration of therapy;
(c) special directions and precautions for use;
(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;
(e) techniques for self-monitoring drug therapy;
(f) proper storage;

(g) prescription refill information; and
(h) action to be taken in the event of a missed dose; and
(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:
(a) the name, address, age, and gender of the recipient;
(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;
(c) the pharmacist's comments on the individual's drug therapy;
(d) name of prescriber; and
(e) name of drug, dose, duration of therapy, and directions for use.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-304 Confidentiality of records.
(1) Information obtained under this part shall be treated as confidential or controlled information under Title 63G, Chapter 2, Government Records Access and Management Act.
(2) The board shall establish procedures ensuring that the information described in Subsection 26B-3-304(16) is held confidential by the pharmacist, being provided to the physician only upon request.
(3) The board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the board. The board may release cumulative nonidentifying information for research purposes.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-305 Drug prior approval program.
(1) A drug prior approval program approved or implemented by the board shall meet the following conditions:
(a) except as provided in Subsection (2), a drug may not be placed on prior approval for other than medical reasons;
(b) the board shall hold a public hearing at least 30 days prior to placing a drug on prior approval;
(c) notwithstanding the provisions of Section 52-4-202, the board shall provide not less than 14 days' notice to the public before holding a public hearing under Subsection (1)(b);
(d) the board shall consider written and oral comments submitted by interested parties prior to or during the hearing held in accordance with Subsection (1)(b);
(e) the board shall provide evidence that placing a drug class on prior approval:
(i) will not impede quality of recipient care; and
(ii) that the drug class is subject to clinical abuse or misuse;
(f) the board shall reconsider its decision to place a drug on prior approval:
(i) no later than nine months after any drug class is placed on prior approval; and
(ii) at a public hearing with notice as provided in Subsection (1)(b);
(g) the program shall provide an approval or denial of a request for prior approval:
(i) by either:
(A) fax;

(B) telephone; or
(C) electronic transmission;
(ii) at least Monday through Friday, except for state holidays; and
(iii) within 24 hours after receipt of the prior approval request;
(h) the program shall provide for the dispensing of at least a 72-hour supply of the drug on the prior approval program:
(i) in an emergency situation; or
(ii) on weekends or state holidays;
(i) the program may be applied to allow acceptable medical use of a drug on prior approval for appropriate off-label indications; and
(j) before placing a drug class on the prior approval program, the board shall:
(i) determine that the requirements of Subsections (1)(a) through (i) have been met; and
(ii) by majority vote, place the drug class on prior approval.
(2) The board may, only after complying with Subsections (1)(b) through (j), consider the cost:
(a) of a drug when placing a drug on the prior approval program; and
(b) associated with including, or excluding a drug from the prior approval process, including:
(i) potential side effects associated with a drug; or
(ii) potential hospitalizations or other complications that may occur as a result of a drug's inclusion on the prior approval process.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-306 Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under Sections 26B-3-302 through 26B-3-309.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-307 Retrospective and prospective DUR.

(1) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.
(2) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (3) and (4).
(3) The retrospective DUR program shall be based on guidelines established by the board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to:
(a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and
(b) assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:
(i) therapeutic appropriateness;
(ii) overutilization or underutilization;
(iii) therapeutic duplication;
(iv) drug-disease contraindications;
(v) drug-drug interactions;
(vi) incorrect drug dosage or duration of drug treatment; and

(vii) clinical abuse and misuse.

(4) The prospective DUR program shall be based on guidelines established by the board and shall provide that, before a prescription is filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:

(a) therapeutic duplication;

(b) drug-drug interactions;

(c) incorrect dosage or duration of treatment;

(d) drug-allergy interactions; and

(e) clinical abuse or misuse.

(5) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician or physician assistant. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-308 Penalties.

Any person who violates the confidentiality provisions of Sections 26B-3-302 through 26B-3-307 is guilty of a class B misdemeanor.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-309 Immunity.

There is no liability on the part of, and no cause of action of any nature arises against any member of the board, its agents, or employees for any action or omission by them in effecting the provisions of Sections 26B-3-302 through 26B-3-307.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-310 Purpose -- Medicaid certification of nursing care facilities.

(1) The Legislature finds:

(a) that an oversupply of nursing care facilities in the state adversely affects the state Medicaid program and the health of the people in the state;

(b) it is in the best interest of the state to prohibit nursing care facilities from receiving Medicaid certification, except as provided by Sections 26B-3-311 through 26B-3-313; and

(c) it is in the best interest of the state to encourage aging nursing care facilities with Medicaid certification to renovate the nursing care facilities' physical facilities so that the quality of life and clinical services for Medicaid residents are preserved.

(2) Medicaid reimbursement of nursing care facility programs is limited to:

(a) the number of nursing care facility programs with Medicaid certification as of May 9, 2016; and

(b) additional nursing care facility programs approved for Medicaid certification under the provisions of Subsections 26B-3-311(5) and (7).

(3) The division may not:

(a) except as authorized by Section 26B-3-311:

(i) process initial applications for Medicaid certification or execute provider agreements with nursing care facility programs; or

(ii) reinstate Medicaid certification for a nursing care facility whose certification expired or was terminated by action of the federal or state government; or

(b) execute a Medicaid provider agreement with a certified program that moves to a different physical facility, except as authorized by Subsection 26B-3-311(3).

(4) Notwithstanding Section 26B-3-311, beginning May 4, 2021, the division may not approve a new or additional bed in an intermediate care facility for individuals with an intellectual disability for Medicaid certification, unless certification of the bed by the division does not increase the total number in the state of Medicaid-certified beds in intermediate care facilities for individuals with an intellectual disability.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-311 Authorization to renew, transfer, or increase Medicaid certified programs -- Reimbursement methodology.

(1)

(a) The division may renew Medicaid certification of a certified program if the program, without lapse in service to Medicaid recipients, has its nursing care facility program certified by the division at the same physical facility as long as the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) The division may renew Medicaid certification of a nursing care facility program that is not currently certified if:

(i) since the day on which the program last operated with Medicaid certification:

(A) the physical facility where the program operated has functioned solely and continuously as a nursing care facility; and

(B) the owner of the program has not, under this section or Section 26B-3-313, transferred to another nursing care facility program the license for any of the Medicaid beds in the program; and

(ii) except as provided in Subsection 26B-3-310(4), the number of beds granted renewed Medicaid certification does not exceed the number of beds certified at the time the program last operated with Medicaid certification, excluding a period of time where the program operated with temporary certification under Subsection 26B-3-312(3).

(2)

(a) The division may issue a Medicaid certification for a new nursing care facility program if a current owner of the Medicaid certified program transfers its ownership of the Medicaid certification to the new nursing care facility program and the new nursing care facility program meets all of the following conditions:

(i) the new nursing care facility program operates at the same physical facility as the previous Medicaid certified program;

(ii) the new nursing care facility program gives a written assurance to the director in accordance with Subsection (4);

(iii) the new nursing care facility program receives the Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient; and

(iv) the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) A nursing care facility program that receives Medicaid certification under the provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing care facility program if the new nursing care facility program:

(i) is not owned in whole or in part by the previous nursing care facility program; or

(ii) is not a successor in interest of the previous nursing care facility program.

(3) The division may issue a Medicaid certification to a nursing care facility program that was previously a certified program but now resides in a new or renovated physical facility if the nursing care facility program meets all of the following:

(a) the nursing care facility program met all applicable requirements for Medicaid certification at the time of closure;

(b) the new or renovated physical facility is in the same county or within a five-mile radius of the original physical facility;

(c) the time between which the certified program ceased to operate in the original facility and will begin to operate in the new physical facility is not more than three years, unless:

(i) an emergency is declared by the president of the United States or the governor, affecting the building or renovation of the physical facility;

(ii) the director approves an exception to the three-year requirement for any nursing care facility program within the three-year requirement;

(iii) the provider submits documentation supporting a request for an extension to the director that demonstrates a need for an extension; and

(iv) the exception does not extend for more than two years beyond the three-year requirement;

(d) if Subsection (3)(c) applies, the certified program notifies the department within 90 days after ceasing operations in its original facility, of its intent to retain its Medicaid certification;

(e) the provider gives written assurance to the director in accordance with Subsection (4) that no third party has a legitimate claim to operate a certified program at the previous physical facility; and

(f) the bed capacity in the physical facility has not been expanded unless the director has approved additional beds in accordance with Subsection (5).

(4)

(a) The entity requesting Medicaid certification under Subsections (2) and (3) shall give written assurances satisfactory to the director or the director's designee that:

(i) no third party has a legitimate claim to operate the certified program;

(ii) the requesting entity agrees to defend and indemnify the department against any claims by a third party who may assert a right to operate the certified program; and

(iii) if a third party is found, by final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

(b) If a finding is made under the provisions of Subsection (4)(a)(iii):

(i) the certified program shall immediately surrender its Medicaid certification and comply with division rules regarding billing for Medicaid and the provision of services to Medicaid patients; and

(ii) the department shall transfer the surrendered Medicaid certification to the third party who prevailed under Subsection (4)(a)(iii).

(5)

(a) The director may approve additional nursing care facility programs for Medicaid certification, or additional beds for Medicaid certification within an existing nursing care facility program, if a nursing care facility or other interested party requests Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program, and the nursing care facility program or other interested party complies with this section.

(b) The nursing care facility or other interested party requesting Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program under Subsection (5)(a) shall submit to the director:

(i) proof of the following as reasonable evidence that bed capacity provided by Medicaid certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient:

(A) nursing care facility occupancy levels for all existing and proposed facilities will be at least 90% for the next three years;

(B) current nursing care facility occupancy is 90% or more; or

(C) there is no other nursing care facility within a 35-mile radius of the nursing care facility requesting the additional certification; and

(ii) an independent analysis demonstrating that at projected occupancy rates the nursing care facility's after-tax net income is sufficient for the facility to be financially viable.

(c) Any request for additional beds as part of a renovation project are limited to the maximum number of beds allowed in Subsection (7).

(d) The director shall determine whether to issue additional Medicaid certification by considering:

(i) whether bed capacity provided by certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient, based on the information submitted to the director under Subsection (5)(b);

(ii) whether the county or group of counties impacted by the requested additional Medicaid certification is underserved by specialized or unique services that would be provided by the nursing care facility;

(iii) whether any Medicaid certified beds are subject to a claim by a previous certified program that may reopen under the provisions of Subsections (2) and (3);

(iv) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of Medicaid recipients; and

(v)

(A) whether the existing certified programs within the county or group of counties have provided services of sufficient quality to merit at least a two-star rating in the Medicare Five-Star Quality Rating System over the previous three-year period; and

(B) information obtained under Subsection (9).

(6) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility property reimbursement methodology to:

(a) only pay that portion of the property component of rates, representing actual bed usage by Medicaid clients as a percentage of the greater of:

(i) actual occupancy; or

(ii)

(A) for a nursing care facility other than a facility described in Subsection (6)(a)(ii)(B), 85% of total bed capacity; or

(B) for a rural nursing care facility, 65% of total bed capacity; and

(b) not allow for increases in reimbursement for property values without major renovation or replacement projects as defined by the department by rule.

(7)

(a) Except as provided in Subsection 26B-3-310(3), if a nursing care facility does not seek Medicaid certification for a bed under Subsections (1) through (6), the department shall, notwithstanding Subsections 26B-3-312(3)(a) and (b), grant Medicaid certification for additional beds in an existing Medicaid certified nursing care facility that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility if:

(i) the nursing care facility program was previously a certified program for all beds but now resides in a new facility or in a facility that underwent major renovations involving major

structural changes, with 50% or greater facility square footage design changes, requiring review and approval by the department;

(ii) the nursing care facility meets the quality of care regulations issued by CMS; and

(iii) the total number of additional beds in the facility granted Medicaid certification under this section does not exceed 10% of the number of licensed beds in the facility.

(b) The department may not revoke the Medicaid certification of a bed under this Subsection (7) as long as the provisions of Subsection (7)(a)(ii) are met.

(8)

(a) If a nursing care facility or other interested party indicates in its request for additional Medicaid certification under Subsection (5)(a) that the facility will offer specialized or unique services, but the facility does not offer those services after receiving additional Medicaid certification, the director shall revoke the additional Medicaid certification.

(b) The nursing care facility program shall obtain Medicaid certification for any additional Medicaid beds approved under Subsection (5) or (7) within three years of the date of the director's approval, or the approval is void.

(9)

(a) If the director makes an initial determination that quality standards under Subsection (5)(d)(v) have not been met in a rural county or group of rural counties over the previous three-year period, the director shall, before approving certification of additional Medicaid beds in the rural county or group of counties:

(i) notify the certified program that has not met the quality standards in Subsection (5)(d)(v) that the director intends to certify additional Medicaid beds under the provisions of Subsection (5)(d)(v); and

(ii) consider additional information submitted to the director by the certified program in a rural county that has not met the quality standards under Subsection (5)(d)(v).

(b) The notice under Subsection (9)(a) does not give the certified program that has not met the quality standards under Subsection (5)(d)(v), the right to legally challenge or appeal the director's decision to certify additional Medicaid beds under Subsection (5)(d)(v).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-312 Appeals of division decision -- Rulemaking authority -- Application of act.

(1) A decision by the director under this part to deny Medicaid certification for a nursing care facility program or to deny additional bed capacity for an existing certified program is subject to review under the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act.

(2) The department shall make rules to administer and enforce Sections 26B-3-310 through 26B-3-313 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3)

(a) In the event the department is at risk for a federal disallowance with regard to a Medicaid recipient being served in a nursing care facility program that is not Medicaid certified, the department may grant temporary Medicaid certification to that facility for up to 24 months.

(b)

(i) The department may extend a temporary Medicaid certification granted to a facility under Subsection (3)(a):

(A) for the number of beds in the nursing care facility occupied by a Medicaid recipient; and

(B) for the period of time during which the Medicaid recipient resides at the facility.

(ii) A temporary Medicaid certification granted under this Subsection (3) is revoked upon:

(A) the discharge of the patient from the facility; or

(B) the patient no longer residing at the facility for any reason.

(c) The department may place conditions on the temporary certification granted under Subsections (3)(a) and (b), such as:

(i) not allowing additional admissions of Medicaid recipients to the program; and

(ii) not paying for the care of the patient after October 1, 2008, with state only dollars.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-313 Authorization to sell or transfer licensed Medicaid beds -- Duties of transferor -- Duties of transferee -- Duties of division.

(1) This section provides a method to transfer or sell the license for a Medicaid bed from a nursing care facility program to another entity that is in addition to the authorization to transfer under Section 26B-3-311.

(2)

(a) A nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds in accordance with Subsection (2)(b) if:

(i) at the time of the transfer, and with respect to the license for the Medicaid bed that will be transferred, the nursing care facility program that will transfer the Medicaid license meets all applicable regulations for Medicaid certification;

(ii) the nursing care facility program gives a written assurance, which is postmarked or has proof of delivery 30 days before the transfer, to the director and to the transferee in accordance with Subsection 26B-3-311(4);

(iii) the nursing care facility program that will transfer the license for a Medicaid bed notifies the division in writing, which is postmarked or has proof of delivery 30 days before the transfer, of:

(A) the number of bed licenses that will be transferred;

(B) the date of the transfer; and

(C) the identity and location of the entity receiving the transferred licenses; and

(iv) if the nursing care facility program for which the license will be transferred or purchased is located in an urban county with a nursing care facility average annual occupancy rate over the previous two years less than or equal to 75%, the nursing care facility program transferring or selling the license demonstrates to the satisfaction of the director that the sale or transfer:

(A) will not result in an excessive number of Medicaid certified beds within the county or group of counties that would be impacted by the transfer or sale; and

(B) best meets the needs of Medicaid recipients.

(b) Except as provided in Subsection (2)(c), a nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds to:

(i) a nursing care facility program that has the same owner or successor in interest of the same owner;

(ii) a nursing care facility program that has a different owner; or

(iii) a related-party nonnursing-care-facility entity that wants to hold one or more of the licenses for a nursing care facility program not yet identified, as long as:

(A) the licenses are subsequently transferred or sold to a nursing care facility program within three years; and

(B) the nursing care facility program notifies the director of the transfer or sale in accordance with Subsection (2)(a)(iii).

(c) A nursing care facility program may not transfer or sell one or more of its licenses for Medicaid beds to an entity under Subsection (2)(b)(i), (ii), or (iii) that is located in a rural county unless the entity requests, and the director issues, Medicaid certification for the beds under Subsection 26B-3-311(5).

(3) A nursing care facility program or entity under Subsection (2)(b)(i), (ii), or (iii) that receives or purchases a license for a Medicaid bed under Subsection (2)(b):

(a) may receive a license for a Medicaid bed from more than one nursing care facility program;

(b) shall give the division notice, which is postmarked or has proof of delivery within 14 days of the nursing care facility program or entity seeking Medicaid certification of beds in the nursing care facility program or entity, of the total number of licenses for Medicaid beds that the entity received and who it received the licenses from;

(c) may only seek Medicaid certification for the number of licensed beds in the nursing care facility program equal to the total number of licenses for Medicaid beds received by the entity;

(d) does not have to demonstrate need or seek approval for the Medicaid licensed bed under Subsection 26B-3-311(5), except as provided in Subsections (2)(a)(iv) and (2)(c) ;

(e) shall meet the standards for Medicaid certification other than those in Subsection 26B-3-311(5), including personnel, services, contracts, and licensing of facilities under Chapter 2, Part 2, Health Care Facility Licensing and Inspection; and

(f) shall obtain Medicaid certification for the licensed Medicaid beds within three years of the date of transfer as documented under Subsection (2)(a)(iii)(B).

(4)

(a) When the division receives notice of a transfer of a license for a Medicaid bed under Subsection (2)(a)(iii)(A), the department shall reduce the number of licenses for Medicaid beds at the transferring nursing care facility:

(i) equal to the number of licenses transferred; and

(ii) effective on the date of the transfer as reported under Subsection (2)(a)(iii)(B).

(b) For purposes of Section 26B-3-310, the division shall approve Medicaid certification for the receiving nursing care facility program or entity:

(i) in accordance with the formula established in Subsection (3)(c); and

(ii) if:

(A) the nursing care facility seeks Medicaid certification for the transferred licenses within the time limit required by Subsection (3)(f); and

(B) the nursing care facility program meets other requirements for Medicaid certification under Subsection (3)(e).

(c) A license for a Medicaid bed may not be approved for Medicaid certification without meeting the requirements of Sections 26B-3-310 and 26B-3-311 if:

(i) the license for a Medicaid bed is transferred under this section but the receiving entity does not obtain Medicaid certification for the licensed bed within the time required by Subsection (3)(f); or

(ii) the license for a Medicaid bed is transferred under this section but the license is no longer eligible for Medicaid certification.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 4
Nursing Care Facility Assessment

26B-3-401 Definitions.

As used in this part:

(1)

(a) "Nursing care facility" means:

(i) a nursing care facility as defined in Section 26B-2-201;

(ii) beginning January 1, 2006, a designated swing bed in:

(A) a general acute hospital as defined in Section 26B-2-201; and

(B) a critical access hospital which meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2) (1998); and

(iii) an intermediate care facility for people with an intellectual disability that is licensed under Section 26B-2-212.

(b) "Nursing care facility" does not include:

(i) the Utah State Developmental Center;

(ii) the Utah State Hospital;

(iii) a general acute hospital, specialty hospital, or small health care facility as those terms are defined in Section 26B-2-201; or

(iv) a Utah State Veterans Home.

(2) "Patient day" means each calendar day in which an individual patient is admitted to the nursing care facility during a calendar month, even if on a temporary leave of absence from the facility.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-402 Legislative findings.

(1) The Legislature finds that there is an important state purpose to improve the quality of care given to persons who are elderly and to people who have a disability, in long-term care nursing facilities.

(2) The Legislature finds that in order to improve the quality of care to those persons described in Subsection (1), the rates paid to the nursing care facilities by the Medicaid program must be adequate to encourage and support quality care.

(3) The Legislature finds that in order to meet the objectives in Subsections (1) and (2), adequate funding must be provided to increase the rates paid to nursing care facilities providing services pursuant to the Medicaid program.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-403 Collection, remittance, and payment of nursing care facilities assessment.

(1)

(a) Beginning July 1, 2004, an assessment is imposed upon each nursing care facility in the amount designated in Subsection (1)(c).

(b)

(i) The department shall establish by rule, a uniform rate per non-Medicare patient day that may not exceed 6% of the total gross revenue for services provided to patients of all nursing care facilities licensed in this state.

(ii) For purposes of Subsection (1)(b)(i), total revenue does not include charitable contribution received by a nursing care facility.

(c) The department shall calculate the assessment imposed under Subsection (1)(a) by multiplying the total number of patient days of care provided to non-Medicare patients by

the nursing care facility, as provided to the department pursuant to Subsection (3)(a), by the uniform rate established by the department pursuant to Subsection (1)(b).

(2)

(a) The assessment imposed by this part is due and payable on a monthly basis on or before the last day of the month next succeeding each monthly period.

(b) The collecting agent for this assessment shall be the department which is vested with the administration and enforcement of this part, including the right to audit records of a nursing care facility related to patient days of care for the facility.

(c) The department shall forward proceeds from the assessment imposed by this part to the state treasurer for deposit in the expendable special revenue fund as specified in Section 26B-1-332.

(3) Each nursing care facility shall, on or before the end of the month next succeeding each calendar monthly period, file with the department:

(a) a report which includes:

(i) the total number of patient days of care the facility provided to non-Medicare patients during the preceding month;

(ii) the total gross revenue the facility earned as compensation for services provided to patients during the preceding month; and

(iii) any other information required by the department; and

(b) a return for the monthly period, and shall remit with the return the assessment required by this part to be paid for the period covered by the return.

(4) Each return shall contain information and be in the form the department prescribes by rule.

(5) The assessment as computed in the return is an allowable cost for Medicaid reimbursement purposes.

(6) The department may by rule, extend the time for making returns and paying the assessment.

(7) Each nursing care facility that fails to pay any assessment required to be paid to the state, within the time required by this part, or that fails to file a return as required by this part, shall pay, in addition to the assessment, penalties and interest as provided in Section 26B-3-404.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-404 Penalties and interest.

(1) The penalty for failure to file a return or pay the assessment due within the time prescribed by this part is the greater of $50, or 1% of the assessment due on the return.

(2) For failure to pay within 30 days of a notice of deficiency of assessment required to be paid, the penalty is the greater of $50 or 5% of the assessment due.

(3) The penalty for underpayment of the assessment is as follows:

(a) If any underpayment of assessment is due to negligence, the penalty is 25% of the underpayment.

(b) If the underpayment of the assessment is due to intentional disregard of law or rule, the penalty is 50% of the underpayment.

(4) For intent to evade the assessment, the penalty is 100% of the underpayment.

(5) The rate of interest applicable to an underpayment of an assessment under this part or an unpaid penalty under this part is 12% annually.

(6) The department may waive the imposition of a penalty for good cause.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-405 Adjustment to nursing care facility Medicaid reimbursement rates.

If federal law or regulation prohibits the money in the Nursing Care Facilities Provider Assessment Fund from being used in the manner set forth in Subsection 26B-1-332(1)(b), the rates paid to nursing care facilities for providing services pursuant to the Medicaid program shall be changed:

(1) except as otherwise provided in Subsection (2), to the rates paid to nursing care facilities on June 30, 2004; or

(2) if the Legislature or the department has on or after July 1, 2004, changed the rates paid to facilities through a manner other than the use of expenditures from the Nursing Care Facilities Provider Assessment Fund, to the rates provided for by the Legislature or the department.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-406 Intermediate care facility for people with an intellectual disability -- Uniform rate.

An intermediate care facility for people with an intellectual disability is subject to all the provisions of this part, except that the department shall establish a uniform rate for an intermediate care facility for people with an intellectual disability that:

(1) is based on the same formula specified for nursing care facilities under the provisions of Subsection 26B-3-403(1)(b); and

(2) may be different than the uniform rate established for other nursing care facilities.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 5
Inpatient Hospital Assessment

26B-3-501 Definitions.

As used in this part:

(1) "Assessment" means the inpatient hospital assessment established by this part.

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

(3) "Discharges" means the number of total hospital discharges reported on:

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.

(4) "Division" means the Division of Integrated Healthcare within the department.

(5) "Enhancement waiver program" means the program established by the Primary Care Network enhancement waiver program described in Section 26B-3-211.

(6) "Health coverage improvement program" means the health coverage improvement program described in Section 26B-3-207.

(7) "Hospital share" means the hospital share described in Section 26B-3-505.

(8) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26B-3-202.

(9) "Medicaid waiver expansion" means a Medicaid expansion in accordance with Section 26B-3-113 or 26B-3-210.
(10) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.
(11)
(a) "Non-state government hospital" means a hospital owned by a non-state government entity.
(b) "Non-state government hospital" does not include:
(i) the Utah State Hospital; or
(ii) a hospital owned by the federal government, including the Veterans Administration Hospital.
(12)
(a) "Private hospital" means:
(i) a general acute hospital, as defined in Section 26B-2-201, that is privately owned and operating in the state; and
(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital whose inpatient admissions are predominantly for:
(A) rehabilitation;
(B) psychiatric care;
(C) chemical dependency services; or
(D) long-term acute care services.
(b) "Private hospital" does not include a facility for residential treatment as defined in Section 26B-2-101.
(13) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.
(14) "Upper payment limit gap" means the difference between the private hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments, as determined in accordance with 42 C.F.R. Sec. 447.321.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-502 Application.
(1) Other than for the imposition of the assessment described in this part, nothing in this part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under any:
(a) state law;
(b) ad valorem property taxes;
(c) sales or use taxes; or
(d) other taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.
(2) All assessments paid under this part may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.
(3) This part does not authorize a political subdivision of the state to:
(a) license a hospital for revenue;
(b) impose a tax or assessment upon a hospital; or
(c) impose a tax or assessment measured by the income or earnings of a hospital.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-503 Assessment.
(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of CMS approval of:
(i) the health coverage improvement program waiver under Section 26B-3-207; and
(ii) the assessment under this part;
(b) in the amount designated in Sections 26B-3-506 and 26B-3-507; and
(c) in accordance with Section 26B-3-504.
(2) Subject to Section 26B-3-505, the assessment imposed by this part is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26B-3-511 have been paid.
(3) The first quarterly payment is not due until at least three months after the earlier of the effective dates of the coverage provided through:
(a) the health coverage improvement program;
(b) the enhancement waiver program; or
(c) the Medicaid waiver expansion.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-504 Collection of assessment -- Deposit of revenue -- Rulemaking.
(1) The collecting agent for the assessment imposed under Section 26B-3-503 is the department.
(2) The department is vested with the administration and enforcement of this part, and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:
(a) collect the assessment, intergovernmental transfers, and penalties imposed under this part;
(b) audit records of a facility that:
(i) is subject to the assessment imposed by this part; and
(ii) does not file a Medicare cost report; and
(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.
(3) The department shall:
(a) administer the assessment in this part separately from the assessment in Part 7, Hospital Provider Assessment; and
(b) deposit assessments collected under this part into the Medicaid Expansion Fund created by Section 26B-1-315.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-505 Quarterly notice.
(1) Quarterly assessments imposed by this part shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.
(2) The department may, by rule, extend the time for paying the assessment.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-506 Hospital financing of health coverage improvement program Medicaid waiver expansion -- Hospital share.
(1) The hospital share is:
(a) 45% of the state's net cost of the health coverage improvement program, including Medicaid coverage for individuals with dependent children up to the federal poverty level designated under Section 26B-3-207;

(b) 45% of the state's net cost of the enhancement waiver program;
(c) if the waiver for the Medicaid waiver expansion is approved, $11,900,000; and
(d) 45% of the state's net cost of the upper payment limit gap.
(2)
(a) The hospital share is capped at no more than $13,600,000 annually, consisting of:
(i) an $11,900,000 cap for the programs specified in Subsections (1)(a) through (c); and
(ii) a $1,700,000 cap for the program specified in Subsection (1)(d).
(b) The department shall prorate the cap described in Subsection (2)(a) in any year in which the programs specified in Subsections (1)(a) and (d) are not in effect for the full fiscal year.
(3) Private hospitals shall be assessed under this part for:
(a) 69% of the portion of the hospital share for the programs specified in Subsections (1)(a) through (c); and
(b) 100% of the portion of the hospital share specified in Subsection (1)(d).
(4)
(a) In the report described in Subsection 26B-3-113(8), the department shall calculate the state's net cost of each of the programs described in Subsections (1)(a) through (c) that are in effect for that year.
(b) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the underpayment or overpayment of the assessment by the private hospitals shall be applied to the fiscal year in which the report is issued.
(5) A Medicaid accountable care organization shall, on or before October 15 of each year, report to the department the following data from the prior state fiscal year for each private hospital, state teaching hospital, and non-state government hospital provider that the Medicaid accountable care organization contracts with:
(a) for the traditional Medicaid population:
(i) hospital inpatient payments;
(ii) hospital inpatient discharges;
(iii) hospital inpatient days; and
(iv) hospital outpatient payments; and
(b) if the Medicaid accountable care organization enrolls any individuals in the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion, for the population newly eligible for any of those programs:
(i) hospital inpatient payments;
(ii) hospital inpatient discharges;
(iii) hospital inpatient days; and
(iv) hospital outpatient payments.
(6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide details surrounding specific content and format for the reporting by the Medicaid accountable care organization.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-507 Calculation of assessment.
(1)
(a) Except as provided in Subsection (1)(b), an annual assessment is payable on a quarterly basis for each private hospital in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).
(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, described in Subsections 26B-3-506(1) and (3), by the sum of:
(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and
(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).
(d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this part.
(e) Any quarterly changes to the uniform assessment rate shall be applied uniformly to all assessed private hospitals.
(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:
(a) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2013, and June 30, 2014; and
(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.
(3)
(a) If a hospital's fiscal year Medicare cost report is not contained in the CMS Healthcare Cost Report Information System file:
(i) the hospital shall submit to the division a copy of the hospital's Medicare cost report applicable to the assessment year; and
(ii) the division shall determine the hospital's discharges.
(b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:
(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;
(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i); and
(iii) failure to submit discharge information shall result in an audit of the hospital's records and a penalty equal to 5% of the calculated assessment.
(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:
(a) the assessment for each hospital shall be separately calculated by the department; and
(b) each separate hospital shall pay the assessment imposed by this part.
(5) If multiple hospitals use the same Medicaid provider number:
(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and
(b) the hospitals may pay the assessment in the aggregate.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-508 State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) The state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund created in Section 26B-1-315, in accordance with this section.
(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of CMS approval of:
(a) the health improvement program waiver under Section 26B-3-207; or
(b) the assessment for private hospitals in this part.
(3) The intergovernmental transfer is apportioned as follows:
(a) the state teaching hospital is responsible for:
(i) 30% of the portion of the hospital share specified in Subsections 26B-3-506(1)(a) through (c); and
(ii) 0% of the hospital share specified in Subsection 26B-3-506(1)(d); and
(b) non-state government hospitals are responsible for:
(i) 1% of the portion of the hospital share specified in Subsections 26B-3-506(1)(a) through (c); and
(ii) 0% of the hospital share specified in Subsection 26B-3-506(1)(d).
(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:
(a) the method of calculating the amounts designated in Subsection (3); and
(b) the schedule for the intergovernmental transfers.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-509 Penalties and interest.
(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this part, within the time required by this part, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.
(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:
(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and
(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:
(i) any unpaid quarterly assessment or intergovernmental transfer; and
(ii) any unpaid penalty assessment.
(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this part.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-510 Hospital reimbursement.
(1) If the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include, in a contract to provide benefits under the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion, a requirement that the Medicaid accountable care

organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.
(2) If the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.
(3) Nothing in this section prohibits a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-511 Outpatient upper payment limit supplemental payments.
(1) Beginning on the effective date of the assessment imposed under this part, and for each subsequent fiscal year, the department shall implement an outpatient upper payment limit program for private hospitals that shall supplement the reimbursement to private hospitals in accordance with Subsection (2).
(2) The division shall ensure that supplemental payment to Utah private hospitals under Subsection (1):
  (a) does not exceed the positive upper payment limit gap; and
  (b) is allocated based on the Medicaid state plan.
(3) The department shall use the same outpatient data to allocate the payments under Subsection (2) and to calculate the upper payment limit gap.
(4) The supplemental payments to private hospitals under Subsection (1) are payable for outpatient hospital services provided on or after the later of:
  (a) July 1, 2016;
  (b) the effective date of the Medicaid state plan amendment necessary to implement the payments under this section; or
  (c) the effective date of the coverage provided through the health coverage improvement program waiver.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-512 Repeal of assessment.
(1) The assessment imposed by this part shall be repealed when:
  (a) the executive director certifies that:
    (i) action by Congress is in effect that disqualifies the assessment imposed by this part from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;
    (ii) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:
      (A) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or
      (B) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this part; or
    (iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015; or
  (b) this part is repealed in accordance with Section 63I-1-226.
(2) If the assessment is repealed under Subsection (1):
  (a) the division may not collect any assessment or intergovernmental transfer under this part;

(b) the department shall disburse money in the special Medicaid Expansion Fund in accordance with the requirements in Subsection 26B-1-315(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;
(c) any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this part shall be refunded to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years; and
(d) any money remaining in the Medicaid Expansion Fund after the disbursements described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of the fiscal year that the assessment is suspended.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 6
Medicaid Expansion Hospital Assessment

26B-3-601 Definitions.

As used in this part:
(1) "Assessment" means the Medicaid expansion hospital assessment established by this part.
(2) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.
(3) "Discharges" means the number of total hospital discharges reported on:
(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or
(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.
(4) "Division" means the Division of Integrated Healthcare within the department.
(5) "Hospital share" means the hospital share described in Section 26B-3-605.
(6) "Medicaid accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26B-3-202.
(7) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26B-1-315.
(8) "Medicaid waiver expansion" means the same as that term is defined in Section 26B-3-210.
(9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.
(10)
(a) "Non-state government hospital" means a hospital owned by a non-state government entity.
(b) "Non-state government hospital" does not include:
(i) the Utah State Hospital; or
(ii) a hospital owned by the federal government, including the Veterans Administration Hospital.
(11)
(a) "Private hospital" means:
(i) a privately owned general acute hospital operating in the state as defined in Section 26B-2-201; or
(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital for which inpatient admissions are predominantly:

(A) rehabilitation;
(B) psychiatric;
(C) chemical dependency; or
(D) long-term acute care services.
(b) "Private hospital" does not include a facility for residential treatment as defined in Section 26B-2-101.
(12) "Qualified Medicaid expansion" means an expansion of the Medicaid program in accordance with Subsection 26B-3-113(5).
(13) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-602 Application.
(1) Other than for the imposition of the assessment described in this part, nothing in this part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under any:
(a) state law;
(b) ad valorem property tax requirement;
(c) sales or use tax requirement; or
(d) other requirements imposed by taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.
(2) A hospital paying an assessment under this part may include the assessment as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.
(3) This part does not authorize a political subdivision of the state to:
(a) license a hospital for revenue;
(b) impose a tax or assessment upon a hospital; or
(c) impose a tax or assessment measured by the income or earnings of a hospital.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-603 Assessment.
(1) An assessment is imposed on each private hospital:
(a) beginning upon the later of:
(i) April 1, 2019; and
(ii) CMS approval of the assessment under this part;
(b) in the amount designated in Sections 26B-3-606 and 26B-3-607; and
(c) in accordance with Section 26B-3-604.
(2) The assessment imposed by this part is due and payable in accordance with Subsection 26B-3-604(4).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-604 Collection of assessment -- Deposit of revenue -- Rulemaking.
(1) The department shall act as the collecting agent for the assessment imposed under Section 26B-3-603.
(2) The department shall administer and enforce the provisions of this part, and may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this part;
(b) audit records of a facility that:
(i) is subject to the assessment imposed under this part; and
(ii) does not file a Medicare cost report; and
(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.
(3) The department shall:
(a) administer the assessment in this part separately from the assessments in Part 7, Hospital Provider Assessment,and Part 5, Inpatient Hospital Assessment; and
(b) deposit assessments collected under this part into the Medicaid Expansion Fund.
(4)
(a) Hospitals shall pay the quarterly assessments imposed by this part to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.
(b) The department may make rules creating requirements to allow the time for paying the assessment to be extended.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-605 Hospital share.
(1) The hospital share is:
(a) for the period from April 1, 2019, through June 30, 2020, $15,000,000; and
(b) beginning July 1, 2020, 100% of the state's net cost of the qualified Medicaid expansion, after deducting appropriate offsets and savings expected as a result of implementing the qualified Medicaid expansion, including:
(i) savings from:
(A) the Primary Care Network program;
(B) the health coverage improvement program, as defined in Section 26B-3-207;
(C) the state portion of inpatient prison medical coverage;
(D) behavioral health coverage; and
(E) county contributions to the non-federal share of Medicaid expenditures; and
(ii) any funds appropriated to the Medicaid Expansion Fund.
(2)
(a) Beginning July 1, 2020, the hospital share is capped at no more than $15,000,000 annually.
(b) Beginning July 1, 2020, the division shall prorate the cap specified in Subsection (2)(a) in any year in which the qualified Medicaid expansion is not in effect for the full fiscal year.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-606 Hospital financing.
(1) Private hospitals shall be assessed under this part for the portion of the hospital share described in Section 26B-3-611.
(2) In the report described in Subsection 26B-3-113(8), the department shall calculate the state's net cost of the qualified Medicaid expansion.
(3) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the division shall apply the underpayment or overpayment of the assessment by the private hospitals to the fiscal year in which the report is issued.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-607 Calculation of assessment.

(1)

(a) Except as provided in Subsection (1)(b), each private hospital shall pay an annual assessment due on the last day of each quarter in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and more than 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection 26B-3-606(1), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this part.

(e) The division shall apply any quarterly changes to the uniform assessment rate uniformly to all assessed private hospitals.

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

(a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

(3)

(a) If a hospital's fiscal year Medicare cost report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare cost report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(b) If a hospital is not certified by the Medicare program and is not required to file a Medicare cost report:

(i) the hospital shall submit to the division the hospital's applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i); and

(iii) if the hospital fails to submit discharge information, the division shall audit the hospital's records and may impose a penalty equal to 5% of the calculated assessment.

(4) Except as provided in Subsection (5), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the division shall calculate the assessment for each hospital separately; and

(b) each separate hospital shall pay the assessment imposed by this part.

(5) If multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and
(b) the hospitals may pay the assessment in the aggregate.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-608 State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) A state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund, in accordance with this section.
(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of:
(a) April 1, 2019; or
(b) CMS approval of the assessment for private hospitals in this part.
(3) The intergovernmental transfer is apportioned between the non-state government hospitals as follows:
(a) the state teaching hospital shall pay for the portion of the hospital share described in Section 26B-3-611; and
(b) non-state government hospitals shall pay for the portion of the hospital share described in Section 26B-3-611.
(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:
(a) the method of calculating the amounts designated in Subsection (3); and
(b) the schedule for the intergovernmental transfers.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-609 Penalties.

(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this part, within the time required by this part, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.
(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:
(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and
(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:
(i) any unpaid quarterly assessment or intergovernmental transfer; and
(ii) any unpaid penalty assessment.
(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive or reduce any of the penalties imposed under this part.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-610 Hospital reimbursement.

(1) If the qualified Medicaid expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include in a contract to

provide benefits under the qualified Medicaid expansion a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

(2) If the qualified Medicaid expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits the department or a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-611 Hospital financing of the hospital share.

(1) For the first two full fiscal years that the assessment is in effect, the department shall:

(a) assess private hospitals under this part for 69% of the hospital share;

(b) require the state teaching hospital to make an intergovernmental transfer under this part for 30% of the hospital share; and

(c) require non-state government hospitals to make an intergovernmental transfer under this part for 1% of the hospital share.

(2)

(a) At the beginning of the third full fiscal year that the assessment is in effect, and at the beginning of each subsequent fiscal year, the department may set a different percentage share for private hospitals, the state teaching hospital, and non-state government hospitals by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, with input from private hospitals and private teaching hospitals.

(b) If the department does not set a different percentage share under Subsection (2)(a), the percentage shares in Subsection (1) shall apply.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-612 Suspension of assessment.

(1) The department shall suspend the assessment imposed by this part when the executive director certifies that:

(a) action by Congress is in effect that disqualifies the assessment imposed by this part from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(b) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(i) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this part; or

(c) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015.

(2) If the assessment is suspended under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this part;

(b) the division shall disburse money in the Medicaid Expansion Fund that was derived from assessments imposed by this part in accordance with the requirements in Subsection

26B-1-315(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment; and

(c) the division shall refund any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this part to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 7
Hospital Provider Assessment

26B-3-701 Definitions.

As used in this part:

(1) "Accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26B-3-202.

(2) "Assessment" means the Medicaid hospital provider assessment established by this part.

(3) "Discharges" means the number of total hospital discharges reported on Worksheet S-3 Part I, column 15, lines 12, 14, and 14.01 of the 2552-96 Medicare Cost Report or on Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare Cost Report for the applicable assessment year.

(4) "Division" means the Division of Integrated Healthcare of the department.

(5) "Hospital":

(a) means a privately owned:

(i) general acute hospital operating in the state as defined in Section 26B-2-201; and

(ii) specialty hospital operating in the state, which shall include a privately owned hospital whose inpatient admissions are predominantly:

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services; and

(b) does not include:

(i) a human services program, as defined in Section 26B-2-101;

(ii) a hospital owned by the federal government, including the Veterans Administration Hospital; or

(iii) a hospital that is owned by the state government, a state agency, or a political subdivision of the state, including:

(A) a state-owned teaching hospital; and

(B) the Utah State Hospital.

(6) "Medicare Cost Report" means CMS-2552-96 or CMS-2552-10, the cost report for electronic filing of hospitals.

(7) "State plan amendment" means a change or update to the state Medicaid plan.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-702 Legislative findings.

(1) The Legislature finds that there is an important state purpose to improve the access of Medicaid patients to quality care in Utah hospitals because of continuous decreases in state revenues and increases in enrollment under the Utah Medicaid program.
(2) The Legislature finds that in order to improve this access to those persons described in Subsection (1):
  (a) the rates paid to Utah hospitals shall be adequate to encourage and support improved access; and
  (b) adequate funding shall be provided to increase the rates paid to Utah hospitals providing services pursuant to the Utah Medicaid program.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-703 Application of part.
(1) Other than for the imposition of the assessment described in this part, nothing in this part shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under:
  (a) Section 501(c), as amended, of the Internal Revenue Code;
  (b) other applicable federal law;
  (c) any state law;
  (d) any ad valorem property taxes;
  (e) any sales or use taxes; or
  (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by the state or any political subdivision, county, municipality, district, authority, or any agency or department thereof.
(2) All assessments paid under this part may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.
(3) This part does not authorize a political subdivision of the state to:
  (a) license a hospital for revenue;
  (b) impose a tax or assessment upon hospitals; or
  (c) impose a tax or assessment measured by the income or earnings of a hospital.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-704 Assessment, collection, and payment of hospital provider assessment.
(1) A uniform, broad based, assessment is imposed on each hospital as defined in Subsection 26B-3-701(5)(a):
  (a) in the amount designated in Section 26B-3-705; and
  (b) in accordance with Section 26B-3-706.
(2)
  (a) The assessment imposed by this part is due and payable on a quarterly basis in accordance with Section 26B-3-706.
  (b) The collecting agent for this assessment is the department which is vested with the administration and enforcement of this part, including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:
    (i) implement and enforce the provisions of this act; and
    (ii) audit records of a facility:
      (A) that is subject to the assessment imposed by this part; and
      (B) does not file a Medicare Cost Report.

(c) The department shall forward proceeds from the assessment imposed by this part to the state treasurer for deposit in the expendable special revenue fund as specified in Section 26B-1-316.

(3) The department may, by rule, extend the time for paying the assessment.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-705 Calculation of assessment.

(1)

(a) An annual assessment is payable on a quarterly basis for each hospital in an amount calculated at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) The uniform assessment rate shall be determined using the total number of hospital discharges for assessed hospitals divided into the total non-federal portion in an amount consistent with Section 26B-3-707 that is needed to support capitated rates for accountable care organizations for purposes of hospital services provided to Medicaid enrollees.

(c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to all assessed hospitals.

(d) The annual uniform assessment rate may not generate more than:

(i) $1,000,000 to offset Medicaid mandatory expenditures; and

(ii) the non-federal share to seed amounts needed to support capitated rates for accountable care organizations as provided for in Subsection (1)(b).

(2)

(a) For each state fiscal year, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file. The hospital's discharge data will be derived as follows:

(i) for state fiscal year 2013, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2009, and June 30, 2010;

(ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2010, and June 30, 2011;

(iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2011, and June 30, 2012;

(iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2012, and June 30, 2013; and

(v) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.

(b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare Cost Report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(c) If a hospital is not certified by the Medicare program and is not required to file a Medicare Cost Report:

(i) the hospital shall submit to the division its applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (2)(c)(i); and

(iii) the failure to submit discharge information shall result in an audit of the hospital's records and a penalty equal to 5% of the calculated assessment.

(3) Except as provided in Subsection (4), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the assessment for each hospital shall be separately calculated by the department; and

(b) each separate hospital shall pay the assessment imposed by this part.

(4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-706 Quarterly notice -- Collection.

Quarterly assessments imposed by this part shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-707 Medicaid hospital adjustment under accountable care organization rates.

(1) To preserve and improve access to hospital services, the division shall incorporate into the accountable care organization rate structure calculation consistent with the certified actuarial rate range:

(a) $154,000,000 to be allocated toward the hospital inpatient directed payments for the Medicaid eligibility categories covered in Utah before January 1, 2019; and

(b) an amount equal to the difference between payments made to hospitals by accountable care organizations for the Medicaid eligibility categories covered in Utah, based on submitted encounter data and the maximum amount that could be paid for those services to be used for directed payments to hospitals for inpatient and outpatient services.

(2)

(a) To preserve and improve the quality of inpatient and outpatient hospital services authorized under Subsection (1)(b), the division shall amend its quality strategies required by 42 C.F.R. Sec. 438.340 to include quality measures selected from the CMS hospital quality improvement programs.

(b) To better address the unique needs of rural and specialty hospitals, the division may adopt different quality standards for rural and specialty hospitals.

(c) The division shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt the selected quality measures and prescribe penalties for not meeting the quality standards that are established by the division by rule.

(d) The division shall apply the same quality measures and penalties under this Subsection (2) to new directed payments made to the University of Utah Hospital and Clinics.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 495, 2023 General Session

26B-3-708 Penalties and interest.

(1) A facility that fails to pay any assessment or file a return as required under this part, within the time required by this part, shall pay, in addition to the assessment, penalties and interest established by the department.

(2)

(a) Consistent with Subsection (2)(b), the department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish reasonable penalties and interest for the violations described in Subsection (1).

(b) If a hospital fails to timely pay the full amount of a quarterly assessment, the department shall add to the assessment:

(i) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:

(A) any unpaid quarterly assessment; and

(B) any unpaid penalty assessment.

(c) Upon making a record of its actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this part.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-709 Repeal of assessment.

(1) The repeal of the assessment imposed by this part shall occur upon the certification by the executive director of the department that the sooner of the following has occurred:

(a) the effective date of any action by Congress that would disqualify the assessment imposed by this part from counting toward state Medicaid funds available to be used to determine the federal financial participation;

(b) the effective date of any decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government that has the effect of:

(i) disqualifying the assessment from counting towards state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creating for any reason a failure of the state to use the assessments for the Medicaid program as described in this part;

(c) the effective date of:

(i) an appropriation for any state fiscal year from the General Fund for hospital payments under the state Medicaid program that is less than the amount appropriated for state fiscal year 2012;

(ii) the annual revenues of the state General Fund budget return to the level that was appropriated for fiscal year 2008;

(iii) a division change in rules that reduces any of the following below July 1, 2011, payments:

(A) aggregate hospital inpatient payments;

(B) adjustment payment rates; or

(C) any cost settlement protocol; or

(iv) a division change in rules that reduces the aggregate outpatient payments below July 1, 2011, payments; and

(d) the sunset of this part in accordance with Section 63I-1-226.

(2) If the assessment is repealed under Subsection (1), money in the fund that was derived from assessments imposed by this part, before the determination made under Subsection (1), shall be disbursed under Section 26B-3-707 to the extent federal matching is not reduced due to the

impermissibility of the assessments. Any funds remaining in the special revenue fund shall be refunded to the hospitals in proportion to the amount paid by each hospital.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 8
Ambulance Service Provider Assessment

26B-3-801 Definitions.

As used in this part:

(1) "Ambulance service provider" means:
  (a) an ambulance provider as defined in Section 26B-4-101; or
  (b) a non-911 service provider as defined in Section 26B-4-101.
(2) "Assessment" means the Medicaid ambulance service provider assessment established by this part.
(3) "Division" means the Division of Integrated Healthcare within the department.
(4) "Non-federal portion" means the non-federal share the division needs to seed amounts that will support fee-for-service ambulance service provider rates, as described in Section 26B-3-804.
(5) "Total transports" means the number of total ambulance transports applicable to a given fiscal year, as determined under Subsection 26B-3-803(5).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-802 Assessment, collection, and payment of ambulance service provider assessment.

(1) An ambulance service provider shall pay an assessment to the division:
  (a) in the amount designated in Section 26B-3-803;
  (b) in accordance with this part;
  (c) quarterly, on a day determined by the division by rule made under Subsection (2)(b); and
  (d) no more than 15 business days after the day on which the division issues the ambulance service provider notice of the assessment.
(2) The division shall:
  (a) collect the assessment described in Subsection (1);
  (b) determine, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, standards and procedures for implementing and enforcing the provisions of this part; and
  (c) transfer assessment proceeds to the state treasurer for deposit into the Ambulance Service Provider Assessment Expendable Revenue Fund created in Section 26B-1-317.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-803 Calculation of assessment.

(1) The division shall calculate a uniform assessment per transport as described in this section.
(2) The assessment due from a given ambulance service provider equals the non-federal portion divided by total transports, multiplied by the number of transports for the ambulance service provider.

(3) The division shall apply any quarterly changes to the assessment rate, calculated as described in Subsection (2), uniformly to all assessed ambulance service providers.
(4) The assessment may not generate more than the total of:
(a) an annual amount of $20,000 to offset Medicaid administration expenses; and
(b) the non-federal portion.
(5)
(a) For each state fiscal year, the division shall calculate total transports using data from the Emergency Medical System as follows:
(i) for state fiscal year 2016, the division shall use ambulance service provider transports during the 2014 calendar year; and
(ii) for a fiscal year after 2016, the division shall use ambulance service provider transports during the calendar year ending 18 months before the end of the fiscal year.
(b) If an ambulance service provider fails to submit transport information to the Emergency Medical System, the division may audit the ambulance service provider to determine the ambulance service provider's transports for a given fiscal year.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-804 Medicaid ambulance service provider adjustment under fee-for-service rates.

The division shall, if the assessment imposed by this part is approved by the Centers for Medicare and Medicaid Services, for fee-for-service rates effective on or after July 1, 2015, reimburse an ambulance service provider in an amount up to the Emergency Medical Services Ambulance Rates adopted annually by the department.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-805 Penalties.

The division shall require an ambulance service provider that fails to pay an assessment due under this part to pay the division, in addition to the assessment, a penalty determined by the division by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-806 Repeal of assessment.

(1) This part is repealed when, as certified by the executive director of the department, any of the following occurs:
(a) an action by Congress that disqualifies the assessment imposed by this part from state Medicaid funds available to be used to determine the federal financial participation takes legal effect; or
(b) an action, decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state or federal government takes effect that:
(i) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or
(ii) creates for any reason a failure of the state to use the assessments for the Medicaid program as described in this part.
(2) If this part is repealed under Subsection (1):

(a) money in the Ambulance Service Provider Assessment Expendable Revenue Fund that was derived from assessments imposed by this part, deposited before the determination made under Subsection (1), shall be disbursed under Section 26B-1-317 to the extent federal matching is not reduced due to the impermissibility of the assessments; and
(b) any funds remaining in the special revenue fund shall be refunded to each ambulance service provider in proportion to the amount paid by the ambulance service provider.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 9
Utah Children's Health Insurance Program

26B-3-901 Definitions.

As used in this part:
(1) "Child" means an individual who is younger than 19 years old.
(2) "Member" means a child enrolled in the program.
(3) "Plan" means the department's plan submitted to the United States Department of Health and Human Services pursuant to 42 U.S.C. Sec. 1397ff.
(4) "Program" means the Utah Children's Health Insurance Program created by this part.
(5) "Traditionally eligible child" means, subject to limitations created by the federal government, a child who is:
(a) a citizen of the United States;
(b) a qualified non-citizen;
(c) a Supplemental Security Income recipient living in the United States on August 22, 1996, that meets the federal government's criteria for one of the grand-fathered Supplemental Security Income recipient non-citizen groups; or
(d) a lawfully present child.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 332, 2023 General Session

26B-3-902 Creation and administration of the Utah Children's Health Insurance Program.

(1) There is created the Utah Children's Health Insurance Program to be administered by the department in accordance with the provisions of:
(a) this part; and
(b) the State Children's Health Insurance Program, 42 U.S.C. Sec. 1397aa et seq.
(2) The department shall:
(a) prepare and submit the state's children's health insurance plan before May 1, 1998, and any amendments to the United States Department of Health and Human Services in accordance with 42 U.S.C. Sec. 1397ff; and
(b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, regarding:
(i) eligibility requirements consistent with Section 26B-3-108;
(ii) program benefits;
(iii) the level of coverage for each program benefit;
(iv) cost-sharing requirements for members, which may not:

(A) exceed the guidelines set forth in 42 U.S.C. Sec. 1397ee; or
(B) impose deductible, copayment, or coinsurance requirements on a member for well-child, well-baby, and immunizations;
(v) the administration of the program; and
(vi) a requirement that:
(A) members in the program shall participate in the electronic exchange of clinical health records established in accordance with Section 26B-8-411 unless the member opts out of participation;
(B) prior to enrollment in the electronic exchange of clinical health records the member shall receive notice of the enrollment in the electronic exchange of clinical health records and the right to opt out of participation at any time; and
(C) beginning July 1, 2012, when the program sends enrollment or renewal information to the member and when the member logs onto the program's website, the member shall receive notice of the right to opt out of the electronic exchange of clinical health records.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-903 Eligibility.

(1) A traditionally eligible child may enroll in the program if the child:
(a) is a bona fide Utah resident;
(b) does not have access to or coverage under other health insurance, including any coverage available through a parent or legal guardian's employer;
(c) is ineligible for Medicaid benefits;
(d) resides in a household whose gross family income, as defined by rule, is at or below 200% of the federal poverty level; and
(e) is not an inmate of a public institution or a patient in an institution for mental diseases.
(2) A child who qualifies for enrollment in the program under Subsection (1) may not be denied enrollment due to a diagnosis or pre-existing condition.
(3)
(a) The department shall determine eligibility and send notification of the eligibility decision within 30 days after receiving the application for coverage.
(b) If the department cannot reach a decision because the applicant fails to take a required action, or because there is an administrative or other emergency beyond the department's control, the department shall:
(i) document the reason for the delay in the applicant's case record; and
(ii) inform the applicant of the status of the application and time frame for completion.
(4) The department may not close enrollment in the program for a child who is eligible to enroll in the program under the provisions of Subsection (1).
(5) The program shall:
(a) apply for grants to make technology system improvements necessary to implement a simplified enrollment and renewal process in accordance with Subsection (5)(b); and
(b) if funding is available, implement a simplified enrollment and renewal process.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 332, 2023 General Session

26B-3-904 Program benefits.

(1) Except as provided in Subsection (3), medical and dental program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, as follows:
(a) medical program benefits, including behavioral health care benefits, shall be benchmarked effective July 1, 2019, and on July 1 every third year thereafter, to:
(i) be substantially equal to a health benefit plan with the largest insured commercial enrollment offered by a health maintenance organization in the state; and
(ii) comply with the Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343; and
(b) dental program benefits shall be benchmarked effective July 1, 2019, and on July 1 every third year thereafter in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, to be substantially equal to a dental benefit plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the state, except that the utilization review mechanism for orthodontia shall be based on medical necessity.
(2) On or before July 1 of each year, the department shall publish the benchmark for dental program benefits established under Subsection (1)(b).
(3) The program benefits:
(a) for enrollees who are at or below 100% of the federal poverty level are exempt from the benchmark requirements of Subsections (1) and (2); and
(b) shall include treatment for autism spectrum disorder as defined in Section 31A-22-642, which:
(i) shall include coverage for applied behavioral analysis; and
(ii) if the benchmark described in Subsection (1)(a) does not include the coverage described in this Subsection (3)(b), the department shall exclude from the benchmark described in Subsection (1)(a) for any purpose other than providing benefits under the program.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-905 Limitation of benefits.

Abortion is not a covered benefit, except as provided in 42 U.S.C. Sec. 1397ee.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-906 Funding.

(1) The program shall be funded by federal matching funds received under, together with state matching funds required by, 42 U.S.C. Sec. 1397ee.
(2) Program expenditures in the following categories may not exceed 10% in the aggregate of all federal payments pursuant to 42 U.S.C. Sec. 1397ee:
(a) other forms of child health assistance for children with gross family incomes below 200% of the federal poverty level;
(b) other health services initiatives to improve low-income children's health;
(c) outreach program expenditures; and
(d) administrative costs.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-907 Evaluation.

The department shall develop performance measures and annually evaluate the program's performance.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-908 Managed care -- Contracting for services.

(1) Program benefits provided to a member under the program, as described in Section 26B-3-904, shall be delivered by a managed care organization if the department determines that adequate services are available where the member lives or resides.

(2) The department may contract with a managed care organization to provide program benefits. The department shall evaluate a potential contract with a managed care organization based on:

(a) the managed care organization's:

(i) ability to manage medical expenses, including mental health costs;

(ii) proven ability to handle accident and health insurance;

(iii) efficiency of claim paying procedures;

(iv) proven ability for managed care and quality assurance;

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) estimated total charges for administering the pool;

(viii) ability to administer the pool in a cost-efficient manner;

(ix) ability to provide adequate providers and services in the state; and

(x) ability to meet quality measures for emergency room use and access to primary care established by the department under Subsection 26B-3-204(4); and

(b) other factors established by the department.

(3) The department may enter into separate managed care organization contracts to provide dental benefits required by Section 26B-3-904.

(4) The department's contract with a managed care organization for the program's benefits shall include risk sharing provisions in which the plan shall accept at least 75% of the risk for any difference between the department's premium payments per member and actual medical expenditures.

(5)

(a) The department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1) if no managed care organization is willing to contract with the department or the department determines no managed care organization meets the criteria established under Subsection (2).

(b) In accordance with Section 49-20-201, a contract awarded under Subsection (5)(a) is not subject to the risk sharing required by Subsection (4).

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-909 State contractor -- Employee and dependent health benefit plan coverage.

(1) For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5b-607, 63C-9-403, 72-6-107.5, and 79-2-404, "qualified health coverage" means, at the time the contract is entered into or renewed:

(a) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of:

(i) the benchmark plan determined by the program under Subsection 26B-3-904(1)(a); and

(ii) a contribution level at which the employer pays at least 50% of the premium or contribution amounts for the employee and the dependents of the employee who reside or work in the state; or

(b) a federally qualified high deductible health plan that, at a minimum:

(i) has a deductible that is:
(A) the lowest deductible permitted for a federally qualified high deductible health plan; or
(B) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;
(ii) has an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and
(iii) provides that the employer pays 60% of the premium or contribution amounts for the employee and the dependents of the employee who work or reside in the state.
(2) The department shall:
(a) on or before July 1, 2016:
(i) determine the commercial equivalent of the benchmark plan described in Subsection (1)(a); and
(ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i) on the department's website, noting the date posted; and
(b) update the posted commercially equivalent benchmark plan annually and at the time of any change in the benchmark.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-910 Alternative eligibility -- Report -- Alternative Eligibility Expendable Revenue Fund.
(1) A child who is not a traditionally eligible child may enroll in the program if:
(a) the child:
(i) has been living in the state for at least 180 days before the day on which the child applies for the program; and
(ii) meets the requirements described in Subsections 26B-3-903(1)(a) through (e); and
(b) the child's parent has unsubsidized employment.
(2)
(a) Enrollment under Subsection (1) is subject to funds in the Alternative Eligibility Expendable Revenue Fund.
(b) The department may create a waiting list for enrollment under Subsection (2)(a) if eligible applicants exceed funds in the Alternative Eligibility Expendable Revenue Fund.
(3) Notwithstanding Section 26B-3-904, the program benefits, coverage, and cost sharing for a child enrolled under this section shall be equal to the benefits, coverage, and cost sharing provided to a child who:
(a) is eligible under Subsection 26B-3-903(1); and
(b) resides in a household that has a gross family income equal to 200% of the federal poverty level.
(4) Notwithstanding Section 26B-3-906, program services provided to a child enrolled under this section shall be funded by the Alternative Eligibility Expendable Revenue Fund.
(5) Each year the department enrolls a child in the program under this section, the department shall submit a report to the Health and Human Services Interim Committee before November 30 detailing:
(a) the number of individuals served under the program;
(b) average duration of coverage for individuals served under the program;
(c) the cost of the program; and

(d) any benefits of the program, including data showing:
(i) percentage of enrolled individuals who had well-child visits with a primary care practitioner at recommended ages;
(ii) percentage of enrolled individuals who received a comprehensive or periodic oral evaluation;
(iii) percentage of enrolled individuals who received recommended immunizations at recommended ages;
(iv) rate of emergency department visits per 1,000 member months;
(v) rate of medication adherence to treat chronic conditions; and
(vi) a comparison of utilization patterns before and after enrollment.

(6)
(a) There is created an expendable special revenue fund known as the "Alternative Eligibility Expendable Revenue Fund."
(b) The Alternative Eligibility Expendable Revenue Fund shall consist of:
(i) appropriations by the Legislature;
(ii) any other funds received as donations for the fund; and
(iii) interest earned on the account.
(c) If the balance of the Alternative Eligibility Expendable Revenue Fund exceeds $4,500,000, state funds shall be transferred from the Alternative Eligibility Expendable Revenue Fund to the General Fund in an amount equal to the amount needed to reduce the balance of the Alternative Eligibility Expendable Revenue Fund to $4,500,000.
(d) Money in the Alternative Eligibility Expendable Revenue Fund shall be used to provide benefits to a child enrolled in the program under this section.

Enacted by Chapter 332, 2023 General Session

Part 10
Medical Benefits Recovery

26B-3-1001 Definitions.

As used in this part:

(1) "Annuity" shall have the same meaning as provided in Section 31A-1-301.
(2) "Care facility" means:
(a) a nursing facility;
(b) an intermediate care facility for an individual with an intellectual disability; or
(c) any other medical institution.
(3) "Claim" means:
(a) a request or demand for payment; or
(b) a cause of action for money or damages arising under any law.
(4) "Employee welfare benefit plan" means a medical insurance plan developed by an employer under 29 U.S.C. Sec. 1001, et seq., the Employee Retirement Income Security Act of 1974 as amended.
(5) "Health insurance entity" means:
(a) an insurer;
(b) a person who administers, manages, provides, offers, sells, carries, or underwrites health insurance, as defined in Section 31A-1-301;

(c) a self-insured plan;
(d) a group health plan, as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;
(e) a service benefit plan;
(f) a managed care organization;
(g) a pharmacy benefit manager;
(h) an employee welfare benefit plan; or
(i) a person who is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(6) "Inpatient" means an individual who is a patient and a resident of a care facility.

(7) "Insurer" includes:
(a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;
(b) a health maintenance organization; and
(c) any entity offering a health service benefit plan.

(8) "Medical assistance" means:
(a) all funds expended for the benefit of a recipient under this chapter or Titles XVIII and XIX, federal Social Security Act; and
(b) any other services provided for the benefit of a recipient by a prepaid health care delivery system under contract with the department.

(9) "Office of Recovery Services" means the Office of Recovery Services within the department.

(10) "Provider" means a person or entity who provides services to a recipient.

(11) "Recipient" means:
(a) an individual who has applied for or received medical assistance from the state;
(b) the guardian, conservator, or other personal representative of an individual under Subsection (11)(a) if the individual is a minor or an incapacitated person; or
(c) the estate and survivors of an individual under Subsection (11)(a), if the individual is deceased.

(12) "Recovery estate" means, regarding a deceased recipient:
(a) all real and personal property or other assets included within a decedent's estate as defined in Section 75-1-201;
(b) the decedent's augmented estate as defined in Section 75-2-203; and
(c) that part of other real or personal property in which the decedent had a legal interest at the time of death including assets conveyed to a survivor, heir, or assign of the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(13) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(14) "TEFRA lien" means a lien, authorized under the Tax Equity and Fiscal Responsibility Act of 1982, against the real property of an individual prior to the individual's death, as described in 42 U.S.C. Sec. 1396p.

(15) "Third party" includes:
(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and
(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or
(ii) has been ordered to maintain health, dental, or accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.
(16) "Trust" shall have the same meaning as provided in Section 75-1-201.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1002 Program established by department -- Promulgation of rules.
(1) The department shall establish and maintain a program for the recoupment of medical assistance.
(2) The department may promulgate rules to implement the purposes of this part.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1003 Assignment of rights to benefits.
(1)
(a) Except as provided in Subsection 26B-3-1009(1), to the extent that medical assistance is actually provided to a recipient, all benefits for medical services or payments from a third-party otherwise payable to or on behalf of a recipient are assigned by operation of law to the department if the department provides, or becomes obligated to provide, medical assistance, regardless of who made application for the benefits on behalf of the recipient.
(b) The assignment:
(i) authorizes the department to submit its claim to the third-party and authorizes payment of benefits directly to the department; and
(ii) is effective for all medical assistance.
(2) The department may recover the assigned benefits or payments in accordance with Section 26B-3-1009 and as otherwise provided by law.
(3)
(a) The assignment of benefits includes medical support and third-party payments ordered, decreed, or adjudged by any court of this state or any other state or territory of the United States.
(b) The assignment is not in lieu of, and does not supersede or alter any other court order, decree, or judgment.
(4) When an assignment takes effect, the recipient is entitled to receive medical assistance, and the benefits paid to the department are a reimbursement to the department.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1004 Health insurance entity -- Duties related to state claims for Medicaid payment or recovery.
As a condition of doing business in the state, a health insurance entity shall:
(1) with respect to an individual who is eligible for, or is provided, medical assistance under the state plan, upon the request of the department, provide information to determine:
(a) during what period the individual, or the spouse or dependent of the individual, may be or may have been, covered by the health insurance entity; and
(b) the nature of the coverage that is or was provided by the health insurance entity described in Subsection (1)(a), including the name, address, and identifying number of the plan;

(2) accept the state's right of recovery and the assignment to the state of any right of an individual to payment from a party for an item or service for which payment has been made under the state plan;
(3) respond to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted no later than three years after the day on which the health care item or service is provided; and
(4) not deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to present proper documentation at the point-of-sale that is the basis for the claim, if:
(a) the claim is submitted no later than three years after the day on which the item or service is furnished; and
(b) any action by the department to enforce the rights of the state with respect to the claim is commenced no later than six years after the day on which the claim is submitted.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1005 Insurance policies not to deny or reduce benefits of individuals eligible for state medical assistance -- Exemptions.
(1) A policy of accident or sickness insurance may not contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for or receiving medical assistance from the state.
(2) An association, corporation, or organization may not deliver, issue for delivery, or renew any subscriber's contract which contains any provisions denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance from the state.
(3) An association, corporation, business, or organization authorized to do business in this state and which provides or pays for any health care benefits may not deny or reduce benefits because services are rendered to a beneficiary who is eligible for or receiving medical assistance from the state.
(4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees' Health Program, administered by the Utah State Retirement Board, is not required to reimburse any agency of state government for custodial care which the agency provides, through its staff or facilities, to members of the Utah State Public Employees' Health Program.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1006 Availability of insurance policy.
If the third party does not pay the department's claim or lien within 30 days from the date the claim or lien is received, the third party shall:
(1) provide a written explanation if the claim is denied;
(2) specifically describe and request any additional information from the department that is necessary to process the claim; and
(3) provide the department or its agent a copy of any relevant or applicable insurance or benefit policy.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1007 Employee benefit plans.

As allowed pursuant to 29 U.S.C. Sec. 1144, an employee benefit plan may not include any provision that has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan based on the fact that the individual is eligible for or is provided services under the state plan.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1008 Statute of limitations -- Survival of right of action -- Insurance policy not to limit time allowed for recovery.

(1)
(a) Subject to Subsection (6), action commenced by the department under this part against a health insurance entity shall be commenced within:
(i) subject to Subsection (7), six years after the day on which the department submits the claim for recovery or payment for the health care item or service upon which the action is based; or
(ii) six months after the date of the last payment for medical assistance, whichever is later.
(b) An action against any other third party, the recipient, or anyone to whom the proceeds are payable shall be commenced within:
(i) four years after the date of the injury or onset of the illness; or
(ii) six months after the date of the last payment for medical assistance, whichever is later.

(2) The death of the recipient does not abate any right of action established by this part.

(3)
(a) No insurance policy issued or renewed after June 1, 1981, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than 24 months from the date the provider furnishes services or goods to the recipient.
(b) No insurance policy issued or renewed after April 30, 2007, may contain any provision that limits the time in which the department may submit its claim to recover medical assistance benefits to a period of less than that described in Subsection (1)(a).

(4) The provisions of this section do not apply to Section 26B-3-1013 or Sections 26B-3-1015 through 26B-3-1023.

(5) The provisions of this section supersede any other sections regarding the time limit in which an action shall be commenced, including Section 75-7-509.

(6)
(a) Subsection (1)(a) extends the statute of limitations on a cause of action described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.
(b) Subsection (1)(a) does not revive a cause of action that was time-barred on or before April 30, 2007.

(7) An action described in Subsection (1)(a) may not be commenced if the claim for recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after the day on which the health care item or service upon which the claim is based was provided.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1009 Recovery of medical assistance from third party -- Lien -- Notice -- Action -- Compromise or waiver -- Recipient's right to action protected.

(1)

(a) Except as provided in Subsection (1)(c), if the department provides or becomes obligated to provide medical assistance to a recipient that a third-party is obligated to pay for, the department may recover the medical assistance directly from the third-party.

(b)

(i) A claim under Subsection (1)(a) or Section 26B-3-1003 to recover medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf of the recipient by the third-party.

(ii) The lien described in Subsection (1)(b)(i) has priority over all other claims to the proceeds, except claims for attorney fees and costs authorized under Subsection 26B-3-1011(2)(c)(ii).

(c)

(i) The department may not recover medical assistance under Subsection (1)(a) if:

(A) the third-party is obligated to pay the recipient for an injury to the recipient's child that occurred while the child was in the physical custody of the child's foster parent;

(B) the child's injury is a physical or mental impairment that requires ongoing medical attention, or limits activities of daily living, for at least one year;

(C) the third-party's payment to the recipient is placed in a trust, annuity, financial account, or other financial instrument for the benefit of the child; and

(D) the recipient makes reasonable efforts to mitigate any other medical assistance costs for the recipient to the state.

(ii) The department is responsible for any repayment to the federal government related to the medical assistance the department is prohibited from recovering under Subsection (1)(c)(i).

(2)

(a) The department shall mail or deliver written notice of the department's claim or lien to the third-party at the third-party's principal place of business or last-known address.

(b) The notice shall include:

(i) the recipient's name;

(ii) the approximate date of illness or injury;

(iii) a general description of the type of illness or injury; and

(iv) if applicable, the general location where the injury is alleged to have occurred.

(3) The department may commence an action on the department's claim or lien in the department's name, but the claim or lien is not enforceable as to a third-party unless:

(a) the third-party receives written notice of the department's claim or lien before the third-party settles with the recipient; or

(b) the department has evidence that the third party had knowledge that the department provided or was obligated to provide medical assistance.

(4) The department may:

(a) waive a claim or lien against a third party in whole or in part; or

(b) compromise, settle, or release a claim or lien.

(5) An action commenced under this section does not bar an action by a recipient or a dependent of a recipient for loss or damage not included in the department's action.

(6) Except as provided in Subsection (1)(c), the department's claim or lien on proceeds under this section is not affected by the transfer of the proceeds to a trust, annuity, financial account, or other financial instrument.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1010 Action by department -- Notice to recipient.

(1)

(a) Within 30 days after commencing an action under Subsection 26B-3-1009(3), the department shall give the recipient, the recipient's guardian, personal representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action by:
(i) personal service or certified mail to the last known address of the person receiving the notice; or
(ii) if no last-known address is available, by publishing a notice:
(A) once a week for three successive weeks in a newspaper of general circulation in the county where the recipient resides; and
(B) in accordance with Section 45-1-101 for three weeks.
(b) Proof of service shall be filed in the action.
(c) The recipient may intervene in the department's action at any time before trial.
(2) The notice required by Subsection (1) shall name the court in which the action is commenced and advise the recipient of:
(a) the right to intervene in the proceeding;
(b) the right to obtain a private attorney; and
(c) the department's right to recover medical assistance directly from the third party.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1011 Notice of claim by recipient -- Department response -- Conditions for proceeding -- Collection agreements.

(1)
(a) A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, without the department's written consent as provided in Subsection (2)(b) or (4).
(b) For purposes of Subsection (1)(a), consent may be obtained if:
(i) a recipient who files a claim, or commences an action against a third party notifies the department in accordance with Subsection (1)(d) within 10 days of the recipient making the claim or commencing an action; or
(ii) an attorney, who has been retained by the recipient to file a claim, or commence an action against a third party, notifies the department in accordance with Subsection (1)(d) of the recipient's claim:
(A) within 30 days after being retained by the recipient for that purpose; or
(B) within 30 days from the date the attorney either knew or should have known that the recipient received medical assistance from the department.
(c) Service of the notice of claim to the department shall be made by certified mail, personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure, to the director of the Office of Recovery Services.
(d) The notice of claim shall include the following information:
(i) the name of the recipient;
(ii) the recipient's Social Security number;
(iii) the recipient's date of birth;
(iv) the name of the recipient's attorney if applicable;
(v) the name or names of individuals or entities against whom the recipient is making the claim, if known;
(vi) the name of the third party's insurance carrier, if known;
(vii) the date of the incident giving rise to the claim; and

(viii) a short statement identifying the nature of the recipient's claim.

(2)

(a) Within 30 days of receipt of the notice of the claim required in Subsection (1), the department shall acknowledge receipt of the notice of the claim to the recipient or the recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the following:

(i) if the department has a claim or lien pursuant to Section 26B-3-1009 or has become obligated to provide medical assistance; and

(ii) whether the department is denying or granting written consent in accordance with Subsection (1)(a).

(b) The department shall provide the recipient's attorney the opportunity to enter into a collection agreement with the department, with the recipient's consent, unless:

(i) the department, prior to the receipt of the notice of the recipient's claim pursuant to Subsection (1), filed a written claim with the third party, the third party agreed to make payment to the department before the date the department received notice of the recipient's claim, and the agreement is documented in the department's record; or

(ii) there has been a failure by the recipient's attorney to comply with any provision of this section by:

(A) failing to comply with the notice provisions of this section;

(B) failing or refusing to enter into a collection agreement;

(C) failing to comply with the terms of a collection agreement with the department; or

(D) failing to disburse funds owed to the state in accordance with this section.

(c)

(i) The collection agreement shall be:

(A) consistent with this section and the attorney's obligation to represent the recipient and represent the state's claim; and

(B) state the terms under which the interests of the department may be represented in an action commenced by the recipient.

(ii) If the recipient's attorney enters into a written collection agreement with the department, or includes the department's claim in the recipient's claim or action pursuant to Subsection (4), the department shall pay attorney fees at the rate of 33.3% of the department's total recovery and shall pay a proportionate share of the litigation expenses directly related to the action.

(d) The department is not required to enter into a collection agreement with the recipient's attorney for collection of personal injury protection under Subsection 31A-22-302(2).

(3)

(a) If the department receives notice pursuant to Subsection (1), and notifies the recipient and the recipient's attorney that the department will not enter into a collection agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or action against the third party if the recipient excludes from the claim:

(i) any medical expenses paid by the department; or

(ii) any medical costs for which the department is obligated to provide medical assistance.

(b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall provide written notice to the third party of the exclusion of the department's claim for expenses under Subsection (3)(a)(i) or (ii).

(4) If the department receives notice pursuant to Subsection (1), and does not respond within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's attorney:

(a) may proceed with the recipient's claim or action against the third party;

(b) may include the state's claim in the recipient's claim or action; and

(c) may not negotiate, compromise, settle, or waive the department's claim without the department's consent.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1012 Department's right to intervene -- Department's interests protected -- Remitting funds -- Disbursements -- Liability and penalty for noncompliance.

(1) The department has an unconditional right to intervene in an action commenced by a recipient against a third party for the purpose of recovering medical costs for which the department has provided or has become obligated to provide medical assistance.

(2)

(a) If the recipient proceeds without complying with the provisions of Section 26B-3-1011, the department is not bound by any decision, judgment, agreement, settlement, or compromise rendered or made on the claim or in the action.

(b) The department:

(i) may recover in full from the recipient, or any party to which the proceeds were made payable, all medical assistance that the department has provided; and

(ii) retains its right to commence an independent action against the third party, subject to Subsection 26B-3-1009(3).

(3) Any amounts assigned to and recoverable by the department pursuant to Sections 26B-3-1003 and 26B-3-1009 collected directly by the recipient shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than five business days after receipt.

(4)

(a) Any amounts assigned to and recoverable by the department pursuant to Sections 26B-3-1003 and 26B-3-1009 collected directly by the recipient's attorney shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services no later than 30 days after the funds are placed in the attorney's trust account.

(b) The date by which the funds shall be remitted to the department may be modified based on agreement between the department and the recipient's attorney.

(c) The department's consent to another date for remittance may not be unreasonably withheld.

(d) If the funds are received by the recipient's attorney, no disbursements shall be made to the recipient or the recipient's attorney until the department's claim has been paid.

(5) A recipient or recipient's attorney who knowingly and intentionally fails to comply with this section is liable to the department for:

(a) the amount of the department's claim or lien pursuant to Subsection (1);

(b) a penalty equal to 10% of the amount of the department's claim; and

(c) attorney fees and litigation expenses related to recovering the department's claim.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1013 Estate and trust recovery.

(1)

(a) Except as provided in Subsection (1)(b), upon a recipient's death, the department may recover from the recipient's recovery estate and any trust, in which the recipient is the grantor and a beneficiary, medical assistance correctly provided for the benefit of the recipient when the recipient was 55 years old or older.

(b) The department may not make an adjustment or a recovery under Subsection (1)(a):

(i) while the deceased recipient's spouse is still living; or

(ii) if the deceased recipient has a surviving child who is:
(A) under 21 years old; or
(B) blind or disabled, as defined in the state plan.
(2)
(a) The amount of medical assistance correctly provided for the benefit of a recipient and recoverable under this section is a lien against the deceased recipient's recovery estate or any trust when the recipient is the grantor and a beneficiary.
(b) The lien holds the same priority as reasonable and necessary medical expenses of the last illness as provided in Section 75-3-805.
(3)
(a) For a lien described in Subsection (2), the department shall provide notice in accordance with Section 38-12-102.
(b) Before final distribution, the department shall perfect the lien as follows:
(i) for an estate, by presenting the lien to the estate's personal representative in accordance with Section 75-3-804; and
(ii) for a trust, by presenting the lien to the trustee in accordance with Section 75-7-510.
(c) The department may file an amended lien before the entry of the final order to close the estate or trust.
(4) Claims against a deceased recipient's inter vivos trust shall be presented in accordance with Sections 75-7-509 and 75-7-510.
(5) Any trust provision that denies recovery for medical assistance is void at the time of its making.
(6) Nothing in this section affects the right of the department to recover Medicaid assistance before a recipient's death under Section 26B-3-1003 or 26B-3-1014.
(7) A lien imposed under this section is of indefinite duration.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1014 Recovery from recipient of incorrectly provided medical assistance.

The department may:
(1) recover medical assistance incorrectly provided, whether due to administrative or factual error or fraud, from the recipient or the recipient's recovery estate; and
(2) pursuant to a judgment, impose a lien against real property of the recipient.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1015 TEFRA liens authorized -- Grounds for TEFRA liens -- Exemptions.

(1) Except as provided in Subsections (2) and (3), the department may impose a TEFRA lien on the real property of an individual for the amount of medical assistance provided for, or to, the individual while the individual is an inpatient in a care facility, if:
(a) the individual is an inpatient in a care facility;
(b) the individual is required, as a condition of receiving services under the state plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
(c) the department determines that the individual cannot reasonably be expected to:
(i) be discharged from the care facility; and
(ii) return to the individual's home.
(2) The department may not impose a lien on the home of an individual described in Subsection (1), if any of the following individuals are lawfully residing in the home:

(a) the spouse of the individual;
(b) a child of the individual, if the child is:
(i) under 21 years old; or
(ii) blind or permanently and totally disabled, as defined in Title 42 U.S.C. Sec. 1382c(a)(3)(F); or
(c) a sibling of the individual, if the sibling:
(i) has an equity interest in the home; and
(ii) resided in the home for at least one year immediately preceding the day on which the individual was admitted to the care facility.
(3) The department may not impose a TEFRA lien on the real property of an individual, unless:
(a) the individual has been an inpatient in a care facility for the 180-day period immediately preceding the day on which the lien is imposed;
(b) the department serves:
(i) a preliminary notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section 26B-3-1017; and
(ii) a final notice of intent to impose a TEFRA lien relating to the real property, in accordance with Section 26B-3-1018; and
(c)
(i) the individual does not file a timely request for review of the department's decision under Title 63G, Chapter 4, Administrative Procedures Act; or
(ii) the department's decision is upheld upon final review or appeal under Title 63G, Chapter 4, Administrative Procedures Act.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1016 Presumption of permanency.

There is a rebuttable presumption that an individual who is an inpatient in a care facility cannot reasonably be expected to be discharged from a care facility and return to the individual's home, if the individual has been an inpatient in a care facility for a period of at least 180 consecutive days.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1017 Preliminary notice of intent to impose a TEFRA lien.

(1) Prior to imposing a TEFRA lien on real property, the department shall serve a preliminary notice of intent to impose a TEFRA lien, on the individual described in Subsection 26B-3-1015(1), who owns the property.
(2) The preliminary notice of intent shall:
(a) be served in person, or by certified mail, on the individual described in Subsection 26B-3-1015(1), and, if the department is aware that the individual has a legally authorized representative, on the representative;
(b) include a statement indicating that, according to the department's records, the individual:
(i) meets the criteria described in Subsections 26B-3-1015(1)(a) and (b);
(ii) has been an inpatient in a care facility for a period of at least 180 days immediately preceding the day on which the department provides the notice to the individual; and
(iii) is legally presumed to be in a condition where it cannot reasonably be expected that the individual will be discharged from the care facility and return to the individual's home;
(c) indicate that the department intends to impose a TEFRA lien on real property belonging to the individual;

(d) describe the real property that the TEFRA lien will apply to;
(e) describe the current amount of, and purpose of, the TEFRA lien;
(f) indicate that the amount of the lien may continue to increase as the individual continues to receive medical assistance;
(g) indicate that the individual may seek to prevent the TEFRA lien from being imposed on the real property by providing documentation to the department that:
(i) establishes that the individual does not meet the criteria described in Subsection 26B-3-1015(1)(a) or (b);
(ii) establishes that the individual has not been an inpatient in a care facility for a period of at least 180 days;
(iii) rebuts the presumption described in Section 26B-3-1016; or
(iv) establishes that the real property is exempt from imposition of a TEFRA lien under Subsection 26B-3-1015(2);
(h) indicate that if the owner fails to provide the documentation described in Subsection (2)(g) within 30 days after the day on which the preliminary notice of intent is served, the department will issue a final notice of intent to impose a TEFRA lien on the real property and will proceed to impose the lien;
(i) identify the type of documentation that the owner may provide to comply with Subsection (2)(g);
(j) describe the circumstances under which a TEFRA lien is required to be released; and
(k) describe the circumstances under which the department may seek to recover the lien.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1018 Final notice of intent to impose a TEFRA lien.

(1) The department may issue a final notice of intent to impose a TEFRA lien on real property if:
(a) a preliminary notice of intent relating to the property is served in accordance with Section 26B-3-1017;
(b) it is at least 30 days after the day on which the preliminary notice of intent was served; and
(c) the department has not received documentation or other evidence that adequately establishes that a TEFRA lien may not be imposed on the real property.
(2) The final notice of intent to impose a TEFRA lien on real property shall:
(a) be served in person, or by certified mail, on the individual described in Subsection 26B-3-1015(1), who owns the property, and, if the department is aware that the individual has a legally authorized representative, on the representative;
(b) indicate that the department has complied with the requirements for filing the final notice of intent under Subsection (1);
(c) include a statement indicating that, according to the department's records, the individual:
(i) meets the criteria described in Subsections 26B-3-1015(1)(a) and (b);
(ii) has been an inpatient in a care facility for a period of at least 180 days immediately preceding the day on which the department provides the notice to the individual; and
(iii) is legally presumed to be in a condition where it cannot reasonably be expected that the individual will be discharged from the care facility and return to the individual's home;
(d) indicate that the department intends to impose a TEFRA lien on real property belonging to the individual;
(e) describe the real property that the TEFRA lien will apply to;
(f) describe the current amount of, and purpose of, the TEFRA lien;

(g) indicate that the amount of the lien may continue to increase as the individual continues to receive medical assistance;
(h) describe the circumstances under which a TEFRA lien is required to be released;
(i) describe the circumstances under which the department may seek to recover the lien;
(j) describe the right of the individual to challenge the decision of the department in an adjudicative proceeding; and
(k) indicate that failure by the individual to successfully challenge the decision of the department will result in the TEFRA lien being imposed.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1019 Review of department decision.

An individual who has been served with a final notice of intent to impose a TEFRA lien under Section 26B-3-1018 may seek agency or judicial review of that decision under Title 63G, Chapter 4, Administrative Procedures Act.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1020 Dissolution and removal of TEFRA lien.

(1) A TEFRA lien shall dissolve and be removed by the department if the individual described in Subsection 26B-3-1015(1):
(a)
(i) is discharged from the care facility; and
(ii) returns to the individual's home; or
(b) provides sufficient documentation to the department that:
(i) rebuts the presumption described in Section 26B-3-1016; or
(ii) any of the following individuals are lawfully residing in the individual's home:
(A) the spouse of the individual;
(B) a child of the individual, if the child is under 21 years old or blind or permanently and totally disabled, as defined in Title 42 U.S.C. Sec. 1382c(a)(3)(F); or
(C) a sibling of the individual, if the sibling has an equity interest in the home and resided in the home for at least one year immediately preceding the day on which the individual was admitted to the care facility.
(2) An individual described in Subsection 26B-3-1015(1)(a) may, at any time after the department has imposed a lien under Sections 26B-3-1015 through 26B-3-1023, file a request for the department to remove the lien.
(3) A request filed under Subsection (2) shall be considered and reviewed pursuant to Title 63G, Chapter 4, Administrative Procedures Act.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1021 Expenditures included in lien -- Other proceedings.

(1) A TEFRA lien imposed on real property under Sections 26B-3-1015 through 26B-3-1023 includes all expenses relating to medical assistance provided or paid for under the state plan from the first day that the individual is placed in a care facility, regardless of when the lien is imposed or filed on the property.

(2) Nothing in Sections 26B-3-1015 through 26B-3-1023 affect or prevent the department from bringing or pursuing any other legally authorized action to recover medical assistance or to set aside a fraudulent or improper conveyance.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1022 Contract with another government agency.

If the department contracts with another government agency to recover funds paid for medical assistance under this part, that government agency shall be the sole agency that determines whether to impose or remove a TEFRA lien under Sections 26B-3-1015 through 26B-3-1023.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1023 Precedence of the Tax Equity and Fiscal Responsibility Act of 1982.

If any provision of Sections 26B-3-1015 through 26B-3-1023 conflict with the requirements of the Tax Equity and Fiscal Responsibility Act of 1982 for imposing a lien against the property of an individual prior to the individual's death, under 42 U.S.C. Sec. 1396p, the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 take precedence and shall be complied with by the department.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1024 Legal recognition of electronic claims records.

Pursuant to Title 46, Chapter 4, Uniform Electronic Transactions Act:

(1) a claim submitted to the department for payment may not be denied legal effect, enforceability, or admissibility as evidence in any court in any civil action because it is in electronic form; and

(2) a third party shall accept an electronic record of payments by the department for medical services on behalf of a recipient as evidence in support of the department's claim.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1025 Direct payment to the department by third party.

(1) Any third party required to make payment to the department pursuant to this part shall make the payment directly to the department or its designee.

(2) The department may negotiate a payment or payment instrument it receives in connection with Subsection (1) without the cosignature or other participation of the recipient or any other party.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1026 Attorney general or county attorney to represent department.

The attorney general or a county attorney shall represent the department in any action commenced under this part.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1027 Department's right to attorney fees and costs.

In any action brought by the department under this part in which it prevails, the department shall recover along with the principal sum and interest, a reasonable attorney fee and costs incurred.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1028 Application of provisions contrary to federal law prohibited.

In no event shall any provision contained in this part be applied contrary to existing federal law.

Renumbered and Amended by Chapter 306, 2023 General Session

Part 11
Utah False Claims Act

26B-3-1101 Definitions.

As used in this part:

(1) "Benefit" means the receipt of money, goods, or any other thing of pecuniary value.

(2) "Claim" means any request or demand for money or property:

(a) made to any:

(i) employee, officer, or agent of the state;

(ii) contractor with the state; or

(iii) grantee or other recipient, whether or not under contract with the state; and

(b) if:

(i) any portion of the money or property requested or demanded was issued from or provided by the state; or

(ii) the state will reimburse the contractor, grantee, or other recipient for any portion of the money or property.

(3) "False statement" or "false representation" means a wholly or partially untrue statement or representation which is:

(a) knowingly made; and

(b) a material fact with respect to the claim.

(4) "Health care provider" means the same as that term is defined in Section 26B-8-411.

(5) "Knowing" and "knowingly":

(a) for purposes of criminal prosecutions for violations of this part, is one of the culpable mental states described in Subsection 26B-3-1108(1); and

(b) for purposes of civil prosecutions for violations of this part, is the required culpable mental state as defined in Subsection 26B-3-1109(1).

(6) "Medical benefit" means a benefit paid or payable to:

(a) a health care provider; or

(b) a recipient or a provider under a program administered by the state under:

(i) Titles V and XIX of the federal Social Security Act;

(ii) Title X of the federal Public Health Services Act;

(iii) the federal Child Nutrition Act of 1966 as amended by Pub. L. No. 94-105; and

(iv) any programs for medical assistance of the state.

(7) "Person" means an individual, corporation, unincorporated association, professional corporation, partnership, or other form of business association.

Renumbered and Amended by Chapter 306, 2023 General Session
Amended by Chapter 331, 2023 General Session

26B-3-1102 False statement or representation relating to medical benefits.

(1) A person may not make or cause to be made a false statement or false representation of a material fact in an application for medical benefits.

(2) A person may not make or cause to be made a false statement or false representation of a material fact for use in determining rights to a medical benefit.

(3) A person, who having knowledge of the occurrence of an event affecting the person's initial or continued right to receive a medical benefit or the initial or continued right of any other person on whose behalf the person has applied for or is receiving a medical benefit, may not conceal or fail to disclose that event with intent to obtain a medical benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1103 Kickbacks or bribes prohibited.

(1) For purposes of this section, kickback or bribe:

(a) includes rebates, compensation, or any other form of remuneration which is:

(i) direct or indirect;

(ii) overt or covert; or

(iii) in cash or in kind; and

(b) does not include a rebate paid to the state under 42 U.S.C. Sec. 1396r-8 or any state supplemental rebates.

(2) A person may not solicit, offer, pay, or receive a kickback or bribe in return for or to induce:

(a) the purchasing, leasing, or ordering of any goods or services for which payment is or may be made in whole or in part pursuant to a medical benefit program; or

(b) the referral of an individual to another person for the furnishing of any goods or services for which payment is or may be made in whole or in part pursuant to a medical benefit program.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1104 False statements or false representations relating to qualification of health institution or facility prohibited -- Felony.

(1) A person may not knowingly, intentionally, or recklessly make, induce, or seek to induce, the making of a false statement or false representation of a material fact with respect to the conditions or operation of an institution or facility in order that the institution or facility may qualify, upon initial certification or upon recertification, as a hospital, skilled nursing facility, intermediate care facility, or home health agency.

(2) A person who violates this section is guilty of a second degree felony.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1105 Conspiracy to defraud prohibited.

A person may not enter into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious, or fraudulent claim for a medical benefit.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1106 False claims for medical benefits prohibited.

(1) A person may not make or present or cause to be made or presented to an employee or officer of the state a claim for a medical benefit:
  (a) which is wholly or partially false, fictitious, or fraudulent;
  (b) for services which were not rendered or for items or materials which were not delivered;
  (c) which misrepresents the type, quality, or quantity of items or services rendered;
  (d) representing charges at a higher rate than those charged by the provider to the general public;
  (e) for items or services which the person or the provider knew were not medically necessary in accordance with professionally recognized standards;
  (f) which has previously been paid;
  (g) for services also covered by one or more private sources when the person or provider knew of the private sources without disclosing those sources on the claim; or
  (h) where a provider:
    (i) unbundles a product, procedure, or group of procedures usually and customarily provided or performed as a single billable product or procedure into artificial components or separate procedures; and
    (ii) bills for each component of the product, procedure, or group of procedures:
      (A) as if they had been provided or performed independently and at separate times; and
      (B) the aggregate billing for the components exceeds the amount otherwise billable for the usual and customary single product or procedure.
(2) In addition to the prohibitions in Subsection (1), a person may not:
  (a) fail to credit the state for payments received from other sources;
  (b) recover or attempt to recover payment in violation of the provider agreement from:
    (i) a recipient under a medical benefit program; or
    (ii) the recipient's family;
  (c) falsify or alter with intent to deceive, any report or document required by state or federal law, rule, or Medicaid provider agreement;
  (d) retain any unauthorized payment as a result of acts described by this section; or
  (e) aid or abet the commission of any act prohibited by this section.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1107 Knowledge of past acts not necessary to establish fact that false statement or representation knowingly made.

In prosecution under this part, it is not necessary to show that the person had knowledge of similar acts having been performed in the past on the part of persons acting on his behalf nor to show that the person had actual notice that the acts by the persons acting on his behalf occurred to establish the fact that a false statement or representation was knowingly made.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1108 Criminal penalties.

(1)
  (a) Except as provided in Subsection (1)(b) the culpable mental state required for a criminal violation of this part is knowingly, intentionally, or recklessly as defined in Section 76-2-103.

(b) The culpable mental state required for a criminal violation of this part for kickbacks and bribes under Section 26B-3-1103 is knowingly and intentionally as defined in Section 76-2-103.
(2) The punishment for a criminal violation of any provision of this part, except as provided under Section 26B-3-1104, is determined by the cumulative value of the funds or other benefits received or claimed in the commission of all violations of a similar nature, and not by each separate violation.
(3) Punishment for criminal violation of this part, except as provided under Section 26B-3-1104, is:
(a) a second degree felony if the value of the property or service is or exceeds $5,000;
(b) a third degree felony if the value of the property or service is or exceeds $1,500 but is less than $5,000;
(c) a class A misdemeanor if the value of the property or service is or exceeds $500 but is less than $1,500; or
(d) a class B misdemeanor if the value of the property or service is less than $500.

Amended by Chapter 111, 2023 General Session
Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1109 Civil penalties.
(1) The culpable mental state required for a civil violation of this part is "knowing" or "knowingly" which:
(a) means that person, with respect to information:
(i) has actual knowledge of the information;
(ii) acts in deliberate ignorance of the truth or falsity of the information; or
(iii) acts in reckless disregard of the truth or falsity of the information; and
(b) does not require a specific intent to defraud.
(2) Any person who violates this part shall, in all cases, in addition to other penalties provided by law, be required to:
(a) make full and complete restitution to the state of all damages that the state sustains because of the person's violation of this part;
(b) pay to the state its costs of enforcement of this part in that case, including the cost of investigators, attorneys, and other public employees, as determined by the state; and
(c) pay to the state a civil penalty equal to:
(i) three times the amount of damages that the state sustains because of the person's violation of this part; and
(ii) not less than $5,000 or more than $10,000 for each claim filed or act done in violation of this part.
(3) Any civil penalties assessed under Subsection (2) shall be awarded by the court as part of its judgment in both criminal and civil actions.
(4) A criminal action need not be brought against a person in order for that person to be civilly liable under this section.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1110 Revocation of license of assisted living facility -- Appointment of receiver.
(1) If the license of an assisted living facility is revoked for violation of this part, the county attorney may file a petition with the district court for the county in which the facility is located for the appointment of a receiver.

(2) The district court shall issue an order to show cause why a receiver should not be appointed returnable within five days after the filing of the petition.
(3)
(a) If the court finds that the facts warrant the granting of the petition, the court shall appoint a receiver to take charge of the facility.
(b) The court may determine fair compensation for the receiver.
(4) A receiver appointed pursuant to this section shall have the powers and duties prescribed by the court.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1111 Presumption based on paid state warrant -- Value of medical benefits -- Repayment of benefits.
(1) In any civil or criminal action brought under this part, a paid state warrant, made payable to the order of a party, creates a presumption that the party received funds from the state.
(2) In any civil or criminal action brought under this part, the value of the benefits received shall be the ordinary or usual charge for similar benefits in the private sector.
(3) In any criminal action under this part, the repayment of funds or other benefits obtained in violation of the provisions of this part does not constitute a defense to, or grounds for dismissal of that action.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1112 Violation of other laws.
(1) The provisions of this part are:
(a) not exclusive, and the remedies provided for in this part are in addition to any other remedies provided for under:
(i) any other applicable law; or
(ii) common law; and
(b) to be liberally construed and applied to:
(i) effectuate the chapter's remedial and deterrent purposes; and
(ii) serve the public interest.
(2) If any provision of this part or the application of this part to any person or circumstance is held unconstitutional:
(a) the remaining provisions of this part are not affected; and
(b) the application of this part to other persons or circumstances are not affected.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1113 Medicaid fraud enforcement.
(1) This part shall be enforced in accordance with this section.
(2) The department is responsible for:
(a)
(i) investigating and prosecuting suspected civil violations of this part; or
(ii) referring suspected civil violations of this part to the attorney general for investigation and prosecution; and
(b) promptly referring suspected criminal violations of this part to the attorney general for criminal investigation and prosecution.

(3) The attorney general has:
(a) concurrent jurisdiction with the department for investigating and prosecuting suspected civil violations of this part; and
(b) exclusive jurisdiction to investigate and prosecute all suspected criminal violations of this part.
(4) The department and the attorney general share concurrent civil enforcement authority under this part and may enter into an interagency agreement regarding the investigation and prosecution of violations of this part in accordance with this section, the requirements of Title XIX of the federal Social Security Act, and applicable federal regulations.
(5)
(a) Any violation of this part which comes to the attention of any state government officer or agency shall be reported to the attorney general or the department.
(b) All state government officers and agencies shall cooperate with and assist in any prosecution for violation of this part.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1114 Investigations -- Civil investigative demands.
(1) The attorney general may take investigative action under Subsection (2) if the attorney general has reason to believe that:
(a) a person has information or custody or control of documentary material relevant to the subject matter of an investigation of an alleged violation of this part;
(b) a person is committing, has committed, or is about to commit a violation of this part; or
(c) it is in the public interest to conduct an investigation to ascertain whether or not a person is committing, has committed, or is about to commit a violation of this part.
(2) In taking investigative action, the attorney general may:
(a) require the person to file on a prescribed form a statement in writing, under oath or affirmation describing:
(i) the facts and circumstances concerning the alleged violation of this part; and
(ii) other information considered necessary by the attorney general;
(b) examine under oath a person in connection with the alleged violation of this part; and
(c) in accordance with Subsections (7) through (18), execute in writing, and serve on the person, a civil investigative demand requiring the person to produce the documentary material and permit inspection and copying of the material.
(3) The attorney general may not release or disclose information that is obtained under Subsection (2)(a) or (b), or any documentary material or other record derived from the information obtained under Subsection (2)(a) or (b), except:
(a) by court order for good cause shown;
(b) with the consent of the person who provided the information;
(c) to an employee of the attorney general or the department;
(d) to an agency of this state, the United States, or another state;
(e) to a special assistant attorney general representing the state in a civil action;
(f) to a political subdivision of this state; or
(g) to a person authorized by the attorney general to receive the information.
(4) The attorney general may use documentary material derived from information obtained under Subsection (2)(a) or (b), or copies of that material, as the attorney general determines necessary in the enforcement of this part, including presentation before a court.
(5)

(a) If a person fails to file a statement as required by Subsection (2)(a) or fails to submit to an examination as required by Subsection (2)(b), the attorney general may file in district court a complaint for an order to compel the person to within a period stated by court order:
(i) file the statement required by Subsection (2)(a); or
(ii) submit to the examination required by Subsection (2)(b).
(b) Failure to comply with an order entered under Subsection (5)(a) is punishable as contempt.
(6) A civil investigative demand shall:
(a) state the rule or statute under which the alleged violation of this part is being investigated;
(b) describe the:
(i) general subject matter of the investigation; and
(ii) class or classes of documentary material to be produced with reasonable specificity to fairly indicate the documentary material demanded;
(c) designate a date within which the documentary material is to be produced; and
(d) identify an authorized employee of the attorney general to whom the documentary material is to be made available for inspection and copying.
(7) A civil investigative demand may require disclosure of any documentary material that is discoverable under the Utah Rules of Civil Procedure.
(8) Service of a civil investigative demand may be made by:
(a) delivering an executed copy of the demand to the person to be served or to a partner, an officer, or an agent authorized by appointment or by law to receive service of process on behalf of that person;
(b) delivering an executed copy of the demand to the principal place of business in this state of the person to be served; or
(c) mailing by registered or certified mail an executed copy of the demand addressed to the person to be served:
(i) at the person's principal place of business in this state; or
(ii) if the person has no place of business in this state, to the person's principal office or place of business.
(9) Documentary material demanded in a civil investigative demand shall be produced for inspection and copying during normal business hours at the office of the attorney general or as agreed by the person served and the attorney general.
(10) The attorney general may not produce for inspection or copying or otherwise disclose the contents of documentary material obtained pursuant to a civil investigative demand except:
(a) by court order for good cause shown;
(b) with the consent of the person who produced the information;
(c) to an employee of the attorney general or the department;
(d) to an agency of this state, the United States, or another state;
(e) to a special assistant attorney general representing the state in a civil action;
(f) to a political subdivision of this state; or
(g) to a person authorized by the attorney general to receive the information.
(11)
(a) With respect to documentary material obtained pursuant to a civil investigative demand, the attorney general shall prescribe reasonable terms and conditions allowing such documentary material to be available for inspection and copying by the person who produced the material or by an authorized representative of that person.
(b) The attorney general may use such documentary material or copies of it as the attorney general determines necessary in the enforcement of this part, including presentation before a court.

(12)
(a) A person may file a complaint, stating good cause, to extend the return date for the demand or to modify or set aside the demand.
(b) A complaint under this Subsection (12) shall be filed in district court before the earlier of:
(i) the return date specified in the demand; or
(ii) the 20th day after the date the demand is served.
(13) Except as provided by court order, a person who has been served with a civil investigative demand shall comply with the terms of the demand.
(14)
(a) A person who has committed a violation of this part in relation to the Medicaid program in this state or to any other medical benefit program administered by the state has submitted to the jurisdiction of this state.
(b) Personal service of a civil investigative demand under this section may be made on the person described in Subsection (14)(a) outside of this state.
(15) This section does not limit the authority of the attorney general to conduct investigations or to access a person's documentary materials or other information under another state or federal law, the Utah Rules of Civil Procedure, or the Federal Rules of Civil Procedure.
(16) The attorney general may file a complaint in district court for an order to enforce the civil investigative demand if:
(a) a person fails to comply with a civil investigative demand; or
(b) copying and reproduction of the documentary material demanded:
(i) cannot be satisfactorily accomplished; and
(ii) the person refuses to surrender the documentary material.
(17) If a complaint is filed under Subsection (16), the court may determine the matter presented and may enter an order to enforce the civil investigative demand.
(18) Failure to comply with a final order entered under Subsection (17) is punishable by contempt.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-1115 Limitation of actions -- Civil acts antedating this section -- Civil burden of proof -- Estoppel -- Joint civil liability -- Venue.
(1) An action under this part may not be brought after the later of:
(a) six years after the date on which the violation was committed; or
(b) three years after the date an official of the state charged with responsibility to act in the circumstances discovers the violation, but in no event more than 10 years after the date on which the violation was committed.
(2) A civil action brought under this part may be brought for acts occurring prior to the effective date of this section if the limitations period set forth in Subsection (1) has not lapsed.
(3) In any civil action brought under this part the state shall be required to prove by a preponderance of evidence, all essential elements of the cause of action including damages.
(4) Notwithstanding any other provision of law, a final judgment rendered in favor of the state in any criminal proceeding under this part, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any civil action under this part which involves the same transaction.
(5) Civil liability under this part shall be joint and several for a violation committed by two or more persons.
(6) Any action brought by the state under this part shall be brought in district court in Salt Lake County or in any county where the defendant resides or does business.

Renumbered and Amended by Chapter 306, 2023 General Session