

1 **HEALTH CARE AMENDMENTS**

2 2019 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: Allen M. Christensen

7 **LONG TITLE**

8 **General Description:**

9 This bill amends provisions relating to the Medical Assistance Act, the Utah Children's
10 Health Insurance Act, and the Mental Health Professional Practice Act.

11 **Highlighted Provisions:**

12 This bill:

- 13 ▶ creates and amends definitions;
- 14 ▶ amends provisions relating to the director of the state Medicaid program;
- 15 ▶ renames the Division of Health Care Financing to the Division of Medicaid and
16 Health Financing;
- 17 ▶ requires the Department of Health to coordinate with the Office of the Inspector
18 General for Medicaid Services;
- 19 ▶ changes provisions related to enrollment and renewal processes for the Medicaid
20 program and the Children's Health Insurance Program;
- 21 ▶ deletes provisions related to the Primary Care Network demonstration waiver;
- 22 ▶ amends provisions related to the spouse of an individual residing in a nursing
23 facility and receiving Medicaid services;
- 24 ▶ amends provisions relating to the Medicaid Expansion Fund;
- 25 ▶ modifies contracting provisions for the Department of Health;
- 26 ▶ eliminates certain reporting requirements;
- 27 ▶ amends benefits benchmark requirements for the Utah Children's Health Insurance
28 Program;
- 29 ▶ expands the scope of services that certain state entities can request from the Public

30 Employees' Health Program;

31 ▶ amends provisions relating to the licensing and scope of practice of certain mental
32 health professionals;

33 ▶ removes certain repealers;

34 ▶ repeals provisions from the Medical Assistance Act related to:

35 • the release of financial information;

36 • a strategic plan for health system reform; and

37 • certain waiver provisions; and

38 ▶ makes clarifying and other technical changes.

39 **Money Appropriated in this Bill:**

40 None

41 **Other Special Clauses:**

42 None

43 **Utah Code Sections Affected:**

44 AMENDS:

45 **26-18-2**, as last amended by Laws of Utah 2000, Chapter 1

46 **26-18-2.1**, as enacted by Laws of Utah 1988, Chapter 21

47 **26-18-2.2**, as last amended by Laws of Utah 2011, Chapter 267

48 **26-18-2.3**, as last amended by Laws of Utah 2012, Chapter 242

49 **26-18-2.5**, as last amended by Laws of Utah 2012, Chapter 279

50 **26-18-3.5**, as last amended by Laws of Utah 2006, Chapter 148

51 **26-18-3.6**, as last amended by Laws of Utah 2015, Chapter 258

52 **26-18-5**, as last amended by Laws of Utah 2011, Chapter 297

53 **26-18-11**, as last amended by Laws of Utah 2011, Chapter 297

54 **26-18-18**, as last amended by Laws of Utah 2018, Chapter 468

55 **26-18-21**, as last amended by Laws of Utah 2018, Chapter 467

56 **26-18-404**, as enacted by Laws of Utah 2007, Chapter 190

57 **26-18-408**, as last amended by Laws of Utah 2017, Chapter 22

- 58 **26-18-410**, as last amended by Laws of Utah 2018, Chapter 193
- 59 **26-18-411**, as last amended by Laws of Utah 2018, Chapter 384
- 60 **26-18-413**, as last amended by Laws of Utah 2018, Chapter 78
- 61 **26-18-415**, as enacted by Laws of Utah 2018, Chapter 468
- 62 **26-18-416**, as enacted by Laws of Utah 2018, Chapter 384
- 63 **26-18-417**, as enacted by Laws of Utah 2018, Chapter 180
- 64 **26-18-418**, as enacted by Laws of Utah 2018, Chapter 408
- 65 **26-18-501**, as last amended by Laws of Utah 2018, Chapter 330
- 66 **26-18-503**, as last amended by Laws of Utah 2017, Chapter 443
- 67 **26-36b-202**, as last amended by Laws of Utah 2018, Chapters 384 and 468
- 68 **26-36b-208**, as last amended by Laws of Utah 2018, Chapters 384 and 468
- 69 **26-36c-202**, as enacted by Laws of Utah 2018, Chapter 468
- 70 **26-40-102**, as last amended by Laws of Utah 2000, Chapters 1 and 351
- 71 **26-40-103**, as last amended by Laws of Utah 2017, Chapter 74
- 72 **26-40-105**, as last amended by Laws of Utah 2011, Chapter 344
- 73 **26-40-106**, as last amended by Laws of Utah 2015, Chapter 107
- 74 **26-40-110**, as last amended by Laws of Utah 2015, Chapter 107
- 75 **26-40-115**, as last amended by Laws of Utah 2018, Chapter 319
- 76 **26-40-116**, as enacted by Laws of Utah 2013, Chapter 103
- 77 **49-20-401**, as last amended by Laws of Utah 2018, Chapter 281
- 78 **58-60-205**, as last amended by Laws of Utah 2015, Chapters 77 and 323
- 79 **58-60-207**, as enacted by Laws of Utah 1994, Chapter 32
- 80 **58-60-305**, as last amended by Laws of Utah 2015, Chapter 77
- 81 **58-60-307**, as last amended by Laws of Utah 2001, Chapter 40
- 82 **58-60-308**, as last amended by Laws of Utah 2010, Chapter 214
- 83 **58-60-407**, as last amended by Laws of Utah 2012, Chapter 179
- 84 **58-60-502**, as last amended by Laws of Utah 2013, Chapter 16
- 85 **58-60-508**, as last amended by Laws of Utah 2016, Chapter 238

- 86 [62A-4a-902](#), as last amended by Laws of Utah 2006, Chapter 116
- 87 [63A-13-102](#), as last amended by Laws of Utah 2015, Chapter 135
- 88 [63I-2-226](#), as last amended by Laws of Utah 2018, Chapters 38 and 281
- 89 [63J-1-315](#), as last amended by Laws of Utah 2016, Chapter 183

90 REPEALS:

- 91 [26-18-3.2](#), as enacted by Laws of Utah 2010, Chapter 347
- 92 [26-18-10](#), as last amended by Laws of Utah 2017, Chapter 74
- 93 [26-18-14](#), as last amended by Laws of Utah 2015, Chapter 283
- 94 [26-18-406](#), as last amended by Laws of Utah 2013, Chapter 167
- 95 [26-18-407](#), as last amended by Laws of Utah 2017, Chapter 22

96

97 *Be it enacted by the Legislature of the state of Utah:*

98 Section 1. Section **26-18-2** is amended to read:

99 **26-18-2. Definitions.**

100 As used in this chapter:

101 (1) "Applicant" means any person who requests assistance under the medical programs
102 of the state.

103 [~~(2) "Client" means a person who the department has determined to be eligible for~~
104 ~~assistance under the Medicaid program or the Utah Medical Assistance Program established~~
105 ~~under Section [26-18-10](#).]~~

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

108 (3) "Division" means the Division of Medicaid and Health [~~Care~~] Financing within the
109 department, established under Section [26-18-2.1](#).

110 (4) "Enrollee" or "member" means an individual whom the department has determined
111 to be eligible for assistance under the Medicaid program.

112 [~~(4)~~] (5) "Medicaid program" means the state program for medical assistance for
113 persons who are eligible under the state plan adopted pursuant to Title XIX of the federal

114 Social Security Act.

115 [~~(5)~~] (6) "Medical [~~or hospital~~] assistance" means services furnished or payments made
116 to or on behalf of [~~recipients of medical or hospital assistance under state medical programs~~] a
117 member.

118 [~~(6)~~] (7) (a) "Passenger vehicle" means a self-propelled, two-axle vehicle intended
119 primarily for operation on highways and used by an applicant or recipient to meet basic
120 transportation needs and has a fair market value below 40% of the applicable amount of the
121 federal luxury passenger automobile tax established in 26 U.S.C. Sec. 4001 and adjusted
122 annually for inflation.

123 (b) "Passenger vehicle" does not include:

- 124 (i) a commercial vehicle, as defined in Section [41-1a-102](#);
- 125 (ii) an off-highway vehicle, as defined in Section [41-1a-102](#); or
- 126 (iii) a motor home, as defined in Section [13-14-102](#).

127 (8) "PPACA" means the same as that term is defined in Section [31A-1-301](#).

128 [~~(7)~~] (9) "Recipient" means a person who has received medical [~~or hospital~~] assistance
129 under the Medicaid program [~~or the Utah Medical Assistance Program established under~~
130 ~~Section [26-18-10](#)~~].

131 Section 2. Section **26-18-2.1** is amended to read:

132 **26-18-2.1. Division -- Creation.**

133 There is created, within the department, the Division of Medicaid and Health [~~Care~~]
134 Financing which shall be responsible for implementing, organizing, and maintaining the
135 Medicaid program and the [~~Utah Medical Assistance Program established in Section [26-18-10](#)~~]
136 Children's Health Insurance Program established in Section [26-40-103](#), in accordance with the
137 provisions of this chapter and applicable federal law.

138 Section 3. Section **26-18-2.2** is amended to read:

139 **26-18-2.2. State Medicaid director -- Appointment -- Responsibilities.**

140 The [~~director of the division~~] state Medicaid director shall be appointed by the
141 governor, after consultation with the executive director, with the advice and consent of the

142 Senate. The [~~director of the division~~] state Medicaid director may employ other employees as
143 necessary to implement the provisions of this chapter, and shall:

- 144 (1) administer the responsibilities of the division as set forth in this chapter;
- 145 (2) [~~prepare and~~] administer the division's budget; and
- 146 (3) establish and maintain a state plan for the Medicaid program in compliance with
147 federal law and regulations.

148 Section 4. Section **26-18-2.3** is amended to read:

149 **26-18-2.3. Division responsibilities -- Emphasis -- Periodic assessment.**

150 (1) In accordance with the requirements of Title XIX of the Social Security Act and
151 applicable federal regulations, the division is responsible for the effective and impartial
152 administration of this chapter in an efficient, economical manner. The division shall:

- 153 (a) establish, on a statewide basis, a program to safeguard against unnecessary or
154 inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate
155 hospital admissions or lengths of stay;
- 156 (b) deny any provider claim for services that fail to meet criteria established by the
157 division concerning medical necessity or appropriateness; and
- 158 (c) place its emphasis on high quality care to recipients in the most economical and
159 cost-effective manner possible, with regard to both publicly and privately provided services.

160 (2) The division shall implement and utilize cost-containment methods, where
161 possible, which may include:

- 162 (a) prepayment and postpayment review systems to determine if utilization is
163 reasonable and necessary;
- 164 (b) preadmission certification of nonemergency admissions;
- 165 (c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;
- 166 (d) second surgical opinions;
- 167 (e) procedures for encouraging the use of outpatient services;
- 168 (f) consistent with Sections **26-18-2.4** and **58-17b-606**, a Medicaid drug program;
- 169 (g) coordination of benefits; and

170 (h) review and exclusion of providers who are not cost effective or who have abused
171 the Medicaid program, in accordance with the procedures and provisions of federal law and
172 regulation.

173 (3) The state medicaid director [~~of the division~~] shall periodically assess the cost
174 effectiveness and health implications of the existing Medicaid program, and consider
175 alternative approaches to the provision of covered health and medical services through the
176 Medicaid program, in order to reduce unnecessary or unreasonable utilization.

177 (4) (a) The department shall ensure Medicaid program integrity by conducting internal
178 audits of the Medicaid program for efficiencies, best practices, [~~fraud, waste, abuse,~~] and cost
179 recovery.

180 (b) The department shall coordinate with the Office of the Inspector General for
181 Medicaid Services created in Section 63A-13-201 to implement Subsection (2) and to address
182 Medicaid fraud, waste, or abuse as described in Section 63A-13-202.

183 (5) The department shall, by December 31 of each year, report to the Social Services
184 Appropriations Subcommittee regarding:

185 (a) measures taken under this section to increase:

186 (i) efficiencies within the program; and

187 (ii) cost avoidance and cost recovery efforts in the program; and

188 (b) results of program integrity efforts under Subsection (4).

189 Section 5. Section **26-18-2.5** is amended to read:

190 **26-18-2.5. Simplified enrollment and renewal process for Medicaid and other**
191 **state medical programs -- Financial institutions.**

192 (1) The department may[~~:(a)~~] apply for grants and accept donations to[~~:(i)~~] make
193 technology system improvements necessary to implement a simplified enrollment and renewal
194 process for the Medicaid program, Utah Premium Partnership, and Primary Care Network
195 Demonstration Project programs[~~; and~~].

196 [~~(ii) conduct an actuarial analysis of the implementation of a basic health care plan in~~
197 ~~the state in 2014 to provide coverage options to individuals from 133% to 200% of the federal~~

198 poverty level; and]

199 [~~(b) if funding is available:~~]

200 [~~(i) implement the simplified enrollment and renewal process in accordance with this~~
201 ~~section; and]~~

202 [~~(ii) conduct the actuarial analysis described in Subsection (1)(a)(ii):]~~

203 [~~(2) The simplified enrollment and renewal process established in this section shall, in~~
204 ~~accordance with Section 59-1-403, provide an eligibility worker a process in which the~~
205 ~~eligibility worker:]~~

206 [~~(a) verifies the applicant's or enrollee's identity;~~]

207 [~~(b) gets consent to obtain the applicant's adjusted gross income from the State Tax~~
208 ~~Commission from:]~~

209 [~~(i) the applicant or enrollee, if the applicant or enrollee filed a single tax return; or]~~

210 [~~(ii) both parties to a joint return, if the applicant filed a joint tax return; and]~~

211 [~~(c) obtains from the State Tax Commission, the adjusted gross income of the applicant~~
212 ~~or enrollee:]~~

213 [~~(3)~~] (2) (a) The department may enter into an agreement with a financial institution
214 doing business in the state to develop and operate a data match system to identify an applicant's
215 or enrollee's assets that:

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

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

220 (b) The department may pay a reasonable fee to a financial institution for compliance
221 with this Subsection [~~(3)~~] (2), as provided in Section 7-1-1006.

222 (c) A financial institution may not be liable under any federal or state law to any person
223 for any disclosure of information or action taken in good faith under this Subsection [~~(3)~~] (2).

224 (d) The department may disclose a financial record obtained from a financial institution
225 under this section only for the purpose of, and to the extent necessary in, verifying eligibility as

226 provided in this section and Section 26-40-105.

227 Section 6. Section 26-18-3.5 is amended to read:

228 **26-18-3.5. Copayments by recipients -- Employer sponsored plans.**

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

232 ~~[(2)(a) The department shall seek approval under the department's Section 1115~~
 233 ~~Medicaid waiver to cap enrollment fees for the Primary Care Network Demonstration Project~~
 234 ~~in accordance with Subsection (2)(b).]~~

235 ~~[(b) Pursuant to a waiver obtained under Subsection (2)(a), the department shall cap~~
 236 ~~enrollment fees for the primary care network at \$15 per year for those persons who, after July~~
 237 ~~1, 2003, are eligible to begin receiving General Assistance under Section 35A-3-401.]~~

238 ~~[(c) Beginning July 1, 2004, and pursuant to a waiver obtained under Subsection (2)(a),~~
 239 ~~the department shall cap enrollment fees for the primary care network at \$25 per year for those~~
 240 ~~persons who have an income level that is below 50% of the federal poverty level.]~~

241 ~~[(3)]~~ (2) Beginning May 1, 2006, within appropriations by the Legislature and as a
 242 means to increase health care coverage among the uninsured, the department shall take steps to
 243 promote increased participation in employer sponsored health insurance, including:

244 (a) maximizing the health insurance premium subsidy provided under the state's
 245 ~~[Primary Care Network Demonstration Project]~~ 1115 demonstration waiver by:

246 (i) ensuring that state funds are matched by federal funds to the greatest extent
 247 allowable; and

248 (ii) as the department determines appropriate, seeking federal approval to do one or
 249 more of the following:

250 (A) eliminate or otherwise modify the annual enrollment fee;

251 (B) eliminate or otherwise modify the schedule used to determine the level of subsidy
 252 provided to an enrollee each year;

253 (C) reduce the maximum number of participants allowable under the subsidy program;

254 or

255 (D) otherwise modify the program in a manner that promotes enrollment in employer
256 sponsored health insurance; and

257 (b) exploring the use of other options, including the development of a waiver under the
258 Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

259 Section 7. Section **26-18-3.6** is amended to read:

260 **26-18-3.6. Income and resources from institutionalized spouses.**

261 (1) As used in this section:

262 (a) "Community spouse" means the spouse of an institutionalized spouse.

263 (b) (i) "Community spouse monthly income allowance" means an amount by which the
264 minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly
265 income otherwise available to the community spouse, determined without regard to the
266 allowance, except as provided in Subsection (1)(b)(ii).

267 (ii) If a court has entered an order against an institutionalized spouse for monthly
268 income for the support of the community spouse, the community spouse monthly income
269 allowance for the spouse may not be less than the amount of the monthly income so ordered.

270 (c) "Community spouse resource allowance" is [~~an amount by which the greatest of the~~
271 ~~following exceeds the amount of the resources otherwise available to the community spouse:]~~
272 the amount of combined resources that are protected for a community spouse living in the
273 community, which the division shall establish by rule made in accordance with Title 63G,
274 Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the
275 United States Department of Health and Human Services.

276 [~~(i) \$15,804;~~]

277 [~~(ii) the lesser of the spousal share computed under Subsection (4) or \$76,740;~~]

278 [~~(iii) the amount established in a hearing held under Subsection (11); or]~~

279 [~~(iv) the amount transferred by court order under Subsection (12)(c).]~~

280 (d) "Excess shelter allowance" for a community spouse means the amount by which the
281 sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case

282 of condominium or cooperative, required maintenance charge, for the community spouse's
283 principal residence and the spouse's actual expenses for electricity, natural gas, and water
284 utilities or, at the discretion of the department, the federal standard utility allowance under
285 SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection
286 (9).

287 (e) "Family member" means a minor dependent child, dependent parents, or dependent
288 sibling of the institutionalized spouse or community spouse who are residing with the
289 community spouse.

290 (f) (i) "Institutionalized spouse" means a person who is residing in a nursing facility
291 and is married to a spouse who is not in a nursing facility.

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

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

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

297 (3) For services furnished during a calendar year beginning on or after January 1, 1999,
298 the [~~dollar amounts specified in Subsections (1)(c)(i), (1)(c)(ii), and (10)(b)~~] community spouse
299 resource allowance shall be increased by the division by [~~the~~] an amount as determined
300 annually by [~~the federal Centers for Medicare and Medicaid Services~~] CMS.

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

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

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

306 (5) At the request of an institutionalized spouse or a community spouse, at the
307 beginning of the first continuous period of institutionalization of the institutionalized spouse
308 and upon the receipt of relevant documentation of resources, the division shall promptly assess
309 and document the total value described in Subsection (4)(a) and shall provide a copy of that

310 assessment and documentation to each spouse and shall retain a copy of the assessment. When
311 the division provides a copy of the assessment, it shall include a notice stating that the spouse
312 may request a hearing under Subsection (11).

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

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

317 (b) Resources are considered to be available to the institutionalized spouse only to the
318 extent that the amount of those resources exceeds the ~~[amounts specified in Subsections~~
319 ~~(1)(c)(i) through (iv)]~~ community spouse resource allowance at the time of application for
320 medical assistance under this chapter.

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

324 ~~[(a)]~~ (i) the institutionalized spouse has assigned to the state any rights to support from
325 the community spouse;

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

328 ~~[(ii) Subsection (7)(b)(i) does not prevent the division from seeking a court order~~
329 ~~seeking an assignment of support, or]~~

330 ~~[(c)]~~ (iii) the division determines that denial of medical assistance would cause an
331 undue burden.

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

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

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

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

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

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

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

351 (10) [~~(a) Except as provided in Subsection (10)(b), the~~] The division shall establish a
352 minimum monthly maintenance needs allowance for each community spouse [~~which is not less~~
353 ~~than the sum of~~] that includes:

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

357 [~~(i) 150% of the current poverty guideline for a two-person family unit that applies to~~
358 ~~this state as established by the United States Department of Health and Human Services; and]~~

359 [(ii)] (b) an excess shelter allowance.

360 [~~(b) The amount provided in Subsection (10)(a) may not exceed \$1,976, unless a court~~
361 ~~order establishes a higher amount.]~~

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

365 (b) A hearing under this subsection regarding the community spouse resource

366 allowance shall be held by the division within 90 days from the date of the request for the
367 hearing.

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

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

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

- 380 (i) the community spouse monthly income allowance;
- 381 (ii) the amount of monthly income otherwise available to the community spouse;
- 382 (iii) the computation of the spousal share of resources under Subsection (4);
- 383 (iv) the attribution of resources under Subsection (6); or
- 384 (v) the determination of the community spouse resource allocation.

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

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

391 (c) Chapter 19, Medical Benefits Recovery Act, does not apply if a court has entered an
392 order against an institutionalized spouse for the support of the community spouse.

393 Section 8. Section **26-18-5** is amended to read:

394 **26-18-5. Contracts for provision of medical services -- Federal provisions**
395 **modifying department rules -- Compliance with Social Security Act.**

396 (1) The department may contract with other public or private agencies to purchase or
397 provide medical services in connection with the programs of the division. Where these
398 programs are used by other state agencies, contracts shall provide that other state agencies
399 transfer the state matching funds to the department in amounts sufficient to satisfy needs of the
400 specified program.

401 ~~[(2) All contracts for the provision or purchase of medical services shall be established~~
402 ~~on the basis of the state's fiscal year and shall remain uniform during the fiscal year insofar as~~
403 ~~possible.]~~

404 (2) Contract terms shall include provisions for maintenance, administration, and
405 service costs.

406 (3) If a federal legislative or executive provision requires modifications or revisions in
407 an eligibility factor established under this chapter as a condition for participation in medical
408 assistance, the department may modify or change its rules as necessary to qualify for
409 participation~~[; providing, the]~~.

410 (4) The provisions of this section do not apply to department rules governing abortion.

411 ~~[(4)]~~ (5) The department shall comply with all pertinent requirements of the Social
412 Security Act and all orders, rules, and regulations adopted thereunder when required as a
413 condition of participation in benefits under the Social Security Act.

414 Section 9. Section **26-18-11** is amended to read:

415 **26-18-11. Rural hospitals.**

416 (1) For purposes of this section "rural hospital" means a hospital located outside of a
417 standard metropolitan statistical area, as designated by the United States Bureau of the Census.

418 (2) For purposes of the Medicaid program ~~[and the Utah Medical Assistance Program]~~,
419 the Division of Medicaid and Health ~~[Care]~~ Financing may not discriminate among rural
420 hospitals on the basis of size.

421 Section 10. Section **26-18-18** is amended to read:

422 **26-18-18. Optional Medicaid expansion.**

423 [~~(1)~~ For purposes of this section:]

424 [~~(a)~~ "CMS" means the Centers for Medicare and Medicaid Services within the United
425 States Department of Health and Human Services.]

426 [~~(b)~~ "PPACA" means the same as that term is defined in Section ~~31A-1-301~~.]

427 [~~(2)~~] (1) The department and the governor may not expand the state's Medicaid
428 program under PPACA unless:

429 (a) the department expands Medicaid in accordance with Section 26-18-415; or

430 (b) (i) the governor or the governor's designee has reported the intention to expand the
431 state Medicaid program under PPACA to the Legislature in compliance with the legislative
432 review process in [~~Sections 63N-11-106 and~~] Section 26-18-3; and

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

436 [~~(3)~~] (2) (a) The department shall request approval from CMS for waivers from federal
437 statutory and regulatory law necessary to implement the health coverage improvement program
438 under Section 26-18-411.

439 (b) The health coverage improvement program under Section 26-18-411 is not subject
440 to the requirements in Subsection [~~(2)~~] (1).

441 Section 11. Section 26-18-21 is amended to read:

442 **26-18-21. Medicaid intergovernmental transfer report -- Approval requirements.**

443 (1) As used in this section:

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

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

446 (B) from a nonfederal, government owned health care facility regulated under Chapter
447 21, Health Care Facility Licensing and Inspection Act, to another nonfederal governmental
448 entity.

449 (ii) "Intergovernmental transfer" does not include:

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

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

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

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

457 (c) "Local government entity" means a county, city, town, special service district, local
458 district, or local education agency as that term is defined in Section 63J-5-102.

459 (d) "Non-state government entity" means a hospital authority, hospital district, health
460 care district, special service district, county, or city.

461 (2) (a) An entity that receives federal Medicaid dollars from the department as a result
462 of an intergovernmental transfer shall, on or before August 1, 2017, and on or before August 1
463 each year thereafter, provide the department with:

464 (i) information regarding the payments funded with the intergovernmental transfer as
465 authorized by and consistent with state and federal law;

466 (ii) information regarding the entity's ability to repay federal funds, to the extent
467 required by the department in the contract for the intergovernmental transfer; and

468 (iii) other information reasonably related to the intergovernmental transfer that may be
469 required by the department in the contract for the intergovernmental transfer.

470 (b) On or before October 15, 2017, and on or before October 15 each subsequent year,
471 the department shall prepare a report for the Executive Appropriations Committee that
472 includes:

473 (i) the amount of each intergovernmental transfer under Subsection (2)(a);

474 (ii) a summary of changes to ~~[the Centers for Medicare and Medicaid Services]~~ CMS
475 regulations and practices that are known by the department regarding federal funds related to
476 an intergovernmental transfer program; and

477 (iii) other information the department gathers about the intergovernmental transfer

478 under Subsection (2)(a).

479 (3) The department shall not create a new intergovernmental transfer program after
480 July 1, 2017, unless the department reports to the Executive Appropriations Committee, in
481 accordance with Section [63J-5-206](#), before submitting the new intergovernmental transfer
482 program for federal approval. The report shall include information required by Subsection
483 [63J-5-102\(1\)\(d\)](#) and the analysis required in Subsections (2)(a) and (b).

484 (4) (a) The department shall enter into new Nursing Care Facility Non-State
485 Government-Owned Upper Payment Limit program contracts and contract amendments adding
486 new nursing care facilities and new non-state government entity operators in accordance with
487 this Subsection (4).

488 (b) (i) If the nursing care facility expects to receive less than \$1,000,000 in federal
489 funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment
490 Limit program, excluding seed funding and administrative fees paid by the non-state
491 government entity, the department shall enter into a Nursing Care Facility Non-State
492 Government-Owned Upper Payment Limit program contract with the non-state government
493 entity operator of the nursing care facility.

494 (ii) If the nursing care facility expects to receive between \$1,000,000 and \$10,000,000
495 in federal funds each year from the Nursing Care Facility Non-State Government-Owned
496 Upper Payment Limit program, excluding seed funding and administrative fees paid by the
497 non-state government entity, the department shall enter into a Nursing Care Facility Non-State
498 Government-Owned Upper Payment Limit program contract with the non-state government
499 entity operator of the nursing care facility after receiving the approval of the Executive
500 Appropriations Committee.

501 (iii) If the nursing care facility expects to receive more than \$10,000,000 in federal
502 funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment
503 Limit program, excluding seed funding and administrative fees paid by the non-state
504 government entity, the department may not approve the application without obtaining approval
505 from the Legislature and the governor.

506 (c) A non-state government entity may not participate in the Nursing Care Facility
507 Non-State Government-Owned Upper Payment Limit program unless the non-state government
508 entity is a special service district, county, or city that operates a hospital or holds a license
509 under Chapter 21, Health Care Facility Licensing and Inspection Act.

510 (d) Each non-state government entity that participates in the Nursing Care Facility
511 Non-State Government-Owned Upper Payment Limit program shall certify to the department
512 that:

513 (i) the non-state government entity is a local government entity that is able to make an
514 intergovernmental transfer under applicable state and federal law;

515 (ii) the non-state government entity has sufficient public funds or other permissible
516 sources of seed funding that comply with the requirements in 42 C.F.R. Part 433, Subpart B;

517 (iii) the funds received from the Nursing Care Facility Non-State Government-Owned
518 Upper Payment Limit program are:

519 (A) for each nursing care facility, available for patient care until the end of the
520 non-state government entity's fiscal year; and

521 (B) used exclusively for operating expenses for nursing care facility operations, patient
522 care, capital expenses, rent, royalties, and other operating expenses; and

523 (iv) the non-state government entity has completed all licensing, enrollment, and other
524 forms and documents required by federal and state law to register a change of ownership with
525 the department and with [~~the Centers for Medicare and Medicaid Services~~] CMS.

526 (5) The department shall add a nursing care facility to an existing Nursing Care Facility
527 Non-State Government-Owned Upper Payment Limit program contract if:

528 (a) the nursing care facility is managed by or affiliated with the same non-state
529 government entity that also manages one or more nursing care facilities that are included in an
530 existing Nursing Care Facility Non-State Government-Owned Upper Payment Limit program
531 contract; and

532 (b) the non-state government entity makes the certification described in Subsection
533 (4)(d)(ii).

534 (6) The department may not increase the percentage of the administrative fee paid by a
535 non-state government entity to the department under the Nursing Care Facility Non-State
536 Government-Owned Upper Payment Limit program.

537 (7) The department may not condition participation in the Nursing Care Facility
538 Non-State Government-Owned Upper Payment Limit program on:

539 (a) a requirement that the department be allowed to direct or determine the types of
540 patients that a non-state government entity will treat or the course of treatment for a patient in a
541 non-state government nursing care facility; or

542 (b) a requirement that a non-state government entity or nursing care facility post a
543 bond, purchase insurance, or create a reserve account of any kind.

544 (8) The non-state government entity shall have the primary responsibility for ensuring
545 compliance with Subsection (4)(d)(ii).

546 (9) (a) The department may not enter into a new Nursing Care Facility Non-State
547 Government-Owned Upper Payment Limit program contract before January 1, 2019.

548 (b) Subsection (9)(a) does not apply to:

549 (i) a new Nursing Care Facility Non-State Government-Owned Upper Payment Limit
550 program contract that was included in the federal funds request summary under Section
551 [63J-5-201](#) for fiscal year 2018; or

552 (ii) a nursing care facility that is operated or managed by the same company as a
553 nursing care facility that was included in the federal funds request summary under Section
554 [63J-5-201](#) for fiscal year 2018.

555 Section 12. Section **26-18-404** is amended to read:

556 **26-18-404. Home and community-based long-term care -- Room and board**
557 **assistance.**

558 If the department receives approval from [~~the Centers for Medicare and Medicaid~~
559 ~~Services within the U.S. Department of Health and Human Services]~~ CMS to replace the
560 Medicaid program's current FlexCare program with a new program to provide long-term care
561 services in home and community-based settings rather than institutions, the department shall

562 assist in the payment of room and board costs for any person in the new program without
563 sufficient income to fully pay those costs.

564 Section 13. Section **26-18-408** is amended to read:

565 **26-18-408. Incentives to appropriately use emergency department services.**

566 (1) (a) This section applies to the Medicaid program and to the Utah Children's Health
567 Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.

568 (b) For purposes of this section:

569 (i) "Accountable care organization" means a Medicaid or Children's Health Insurance
570 Program administrator that contracts with the Medicaid program or the Children's Health
571 Insurance Program to deliver health care through an accountable care plan.

572 (ii) "Accountable care plan" means a risk based delivery service model authorized by
573 Section **26-18-405** and administered by an accountable care organization.

574 (iii) "Nonemergent care":

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

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

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

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

587 (2) (a) An accountable care organization may, in accordance with Subsections (2)(b)
588 and (c):

589 (i) audit emergency department services provided to a recipient enrolled in the

590 accountable care plan to determine if nonemergent care was provided to the recipient; and

591 (ii) establish differential payment for emergent and nonemergent care provided in an
592 emergency department.

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

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

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

603 (3) An accountable care organization shall:

604 (a) use the savings under Subsection (2) to maintain and improve access to primary
605 care and urgent care services for all of the recipients enrolled in the accountable care plan;

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

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

610 (4) The department shall:

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

613 (i) appropriate emergency department services to recipients enrolled in the accountable
614 care plan;

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

617 (A) delivery of primary care, urgent care, and after hours care through means other than

618 the emergency department;

619 (B) recipient access to primary care providers and community health centers including
620 evening and weekend access; and

621 (C) other innovations for expanding access to primary care; and

622 (iii) quality of care for the accountable care plan members;

623 (b) compare the quality measures developed under Subsection (4)(a) for each
624 accountable care organization and share the data and quality measures developed under
625 Subsection (4)(a) with the Health Data Committee created in Chapter 33a, Utah Health Data
626 Authority Act;

627 (c) apply for a Medicaid waiver and a Children's Health Insurance Program waiver
628 with [~~the Centers for Medicare and Medicaid Services within the United States Department of~~
629 ~~Health and Human Services]~~ CMS, to:

630 (i) allow the program to charge recipients who are enrolled in an accountable care plan
631 a higher copayment for emergency department services; and

632 (ii) develop, by administrative rule, an algorithm to determine assignment of new,
633 unassigned recipients to specific accountable care plans based on the plan's performance in
634 relation to the quality measures developed pursuant to Subsection (4)(a); and

635 (d) before July 1, 2015, convene representatives from the accountable care
636 organizations, pre-paid mental health plans, an organization representing hospitals, an
637 organization representing physicians, and a county mental health and substance abuse authority
638 to discuss alternatives to emergency department care, including:

639 (i) creating increased access to primary care services;

640 (ii) alternative care settings for super-utilizers and individuals with behavioral health or
641 substance abuse issues;

642 (iii) primary care medical and health homes that can be created and supported through
643 enhanced federal match rates, a state plan amendment for integrated care models, or other
644 Medicaid waivers;

645 (iv) case management programs that can:

646 (A) schedule prompt visits with primary care providers within 72 to 96 hours of an
647 emergency department visit;

648 (B) help super-utilizers with behavioral health or substance abuse issues to obtain care
649 in appropriate care settings; and

650 (C) assist with transportation to primary care visits if transportation is a barrier to
651 appropriate care for the recipient; and

652 (v) sharing of medical records between health care providers and emergency
653 departments for Medicaid recipients.

654 (5) The Health Data Committee may publish data in accordance with Chapter 33a,
655 Utah Health Data Authority Act, which compares the quality measures for the accountable care
656 plans.

657 Section 14. Section **26-18-410** is amended to read:

658 **26-18-410. Medicaid waiver for children with disabilities and complex medical**
659 **needs.**

660 (1) As used in this section:

661 (a) "Additional eligibility criteria" means the additional eligibility criteria set by the
662 department under Subsection (4)(e).

663 (b) "Complex medical condition" means a physical condition of an individual that:

664 (i) results in severe functional limitations for the individual; and

665 (ii) is likely to:

666 (A) last at least 12 months; or

667 (B) result in death.

668 (c) "Program" means the program for children with complex medical conditions
669 created in Subsection (3).

670 (d) "Qualified child" means a child who:

671 (i) is less than 19 years old;

672 (ii) is diagnosed with a complex medical condition;

673 (iii) has a condition that meets the definition of disability in 42 U.S.C. Sec. 12102; and

674 (iv) meets the additional eligibility criteria.

675 (2) The department shall apply for a Medicaid home and community-based waiver with
676 ~~[the Centers for Medicare and Medicaid Services within the United States Department of~~
677 ~~Health and Human Services]~~ CMS to implement, within the state Medicaid program, the
678 program described in Subsection (3).

679 (3) If the waiver described in Subsection (2) is approved, the department shall offer a
680 program that:

681 (a) as funding permits, provides treatment for qualified children;

682 (b) accepts applications for the program during periods of open enrollment; and

683 (c) if approved by ~~[the Centers for Medicare and Medicaid Services]~~ CMS:

684 (i) requires periodic reevaluations of an enrolled child's eligibility based on the
685 additional eligibility criteria; and

686 (ii) at the time of reevaluation, allows the department to disenroll a child who does not
687 meet the additional eligibility criteria.

688 (4) The department shall:

689 (a) seek to prioritize, in the waiver described in Subsection (2), entrance into the
690 program based on the:

691 (i) complexity of a qualified child's medical condition; and

692 (ii) financial needs of a qualified child and the qualified child's family;

693 (b) convene a public process to determine:

694 (i) the benefits and services to offer a qualified child under the program; and

695 (ii) additional eligibility criteria for a qualified child;

696 (c) evaluate, on an ongoing basis, the cost and effectiveness of the program;

697 (d) if funding for the program is reduced, develop an evaluation process to reduce the
698 number of children served based on the criteria in Subsection (4)(a); and

699 (e) establish, by rule made in accordance with Title 63G, Chapter 3, Utah

700 Administrative Rulemaking Act, additional eligibility criteria based on the factors described in
701 Subsections (4)(a)(i) and (ii).

702 ~~[(5) The department shall annually report to the Legislature's Health and Human~~
703 ~~Services Interim Committee before November 30 while the waiver is in effect regarding:]~~

704 ~~[(a) the number of qualified children served under the program;]~~

705 ~~[(b) the cost of the program; and]~~

706 ~~[(c) the effectiveness of the program.]~~

707 Section 15. Section **26-18-411** is amended to read:

708 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
709 **-- Expansion of eligibility for adults with dependent children.**

710 (1) For purposes of this section:

711 (a) "Adult in the expansion population" means an individual who:

712 (i) is described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and

713 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
714 individual.

715 ~~[(b) "CMS" means the Centers for Medicare and Medicaid Services within the United~~
716 ~~States Department of Health and Human Services.]~~

717 ~~[(c)] (b) "Enhancement waiver program" means the Primary Care Network~~
718 ~~enhancement waiver program described in Section 26-18-416.~~

719 ~~[(d)] (c) "Federal poverty level" means the poverty guidelines established by the~~
720 ~~Secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec.~~
721 ~~9909(2).~~

722 ~~[(e)] (d) "Health coverage improvement program" means the health coverage~~
723 ~~improvement program described in Subsections (3) through (10).~~

724 ~~[(f)] (e) "Homeless":~~

725 (i) means an individual who is chronically homeless, as determined by the department;
726 and

727 (ii) includes someone who was chronically homeless and is currently living in
728 supported housing for the chronically homeless.

729 ~~[(g)] (f) "Income eligibility ceiling" means the percent of federal poverty level:~~

730 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
731 Chapter 1, Budgetary Procedures Act; and

732 (ii) under which an individual may qualify for Medicaid coverage in accordance with
733 this section.

734 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
735 allow temporary residential treatment for substance abuse, for the traditional Medicaid
736 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that
737 provides rehabilitation services that are medically necessary and in accordance with an
738 individualized treatment plan, as approved by CMS and as long as the county makes the
739 required match under Section 17-43-201.

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

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

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

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

751 (i) through the traditional fee for service Medicaid model in counties without Medicaid
752 accountable care organizations or the state's Medicaid accountable care organization delivery
753 system, where implemented;

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

756 (iii) that integrates behavioral health services and physical health services with
757 Medicaid accountable care organizations in select geographic areas of the state that choose an

758 integrated model; and

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

763 (c) Medicaid accountable care organizations and counties that elect to integrate care
764 under Subsection (5)(b)(iii) shall collaborate on enrollment, engagement of patients, and
765 coordination of services.

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

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

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

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

775 (i) a chronically homeless individual;

776 (ii) if funding is available, an individual:

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

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

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

783 (c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)
784 may remain on the Medicaid program for a 12-month certification period as defined by the
785 department. Eligibility changes made by the department under Subsection (1)~~(g)~~(f) or (6)(b)

786 shall not apply to an individual during the 12-month certification period.

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

790 (8) Before September 30 of each year, the department shall report to the Health and
791 Human Services Interim Committee and to the Executive Appropriations Committee:

- 792 (a) the number of individuals who enrolled in Medicaid under Subsection (6);
- 793 (b) the state cost of providing Medicaid to individuals enrolled under Subsection (6);

794 and

795 (c) recommendations for adjusting the income eligibility ceiling under Subsection (7),
796 and other eligibility criteria under Subsection (6), for the upcoming fiscal year.

797 (9) The current Medicaid program and the health coverage improvement program,
798 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
799 enrollment for an individual who is released from custody and was eligible for or enrolled in
800 Medicaid before incarceration.

801 (10) Notwithstanding Sections [17-43-201](#) and [17-43-301](#), a county does not have to
802 provide matching funds to the state for the cost of providing Medicaid services to newly
803 enrolled individuals who qualify for Medicaid coverage under the health coverage
804 improvement program under Subsection (6).

805 (11) If the enhancement waiver program is implemented, the department:

806 (a) may not accept any new enrollees into the health coverage improvement program
807 after the day on which the enhancement waiver program is implemented;

808 (b) shall transition all individuals who are enrolled in the health coverage improvement
809 program into the enhancement waiver program;

810 (c) shall suspend the health coverage improvement program within one year after the
811 day on which the enhancement waiver program is implemented;

812 (d) shall, within one year after the day on which the enhancement waiver program is
813 implemented, use all appropriations for the health coverage improvement program to

814 implement the enhancement waiver program; and

815 (e) shall work with CMS to maintain any waiver for the health coverage improvement
816 program while the health coverage improvement program is suspended under Subsection
817 (11)(c).

818 (12) If, after the enhancement waiver program takes effect, the enhancement waiver
819 program is repealed or suspended by either the state or federal government, the department
820 shall reinstate the health coverage improvement program and continue to accept new enrollees
821 into the health coverage improvement program in accordance with the provisions of this
822 section.

823 Section 16. Section **26-18-413** is amended to read:

824 **26-18-413. Medicaid waiver for delivery of adult dental services.**

825 (1) (a) Before June 30, 2016, the department shall ask [~~the United States Secretary of~~
826 ~~Health and Human Services~~] CMS to grant waivers from federal statutory and regulatory law
827 necessary for the Medicaid program to provide dental services in the manner described in
828 Subsection (2).

829 (b) Before June 30, 2018, the department shall submit to [~~the Centers for Medicare and~~
830 ~~Medicaid Services~~] CMS a request for waivers, or an amendment of existing waivers, from
831 federal law necessary for the state to provide dental services, in accordance with Subsections
832 (2)(b) through (g), to an individual described in Subsection (2)(b).

833 (2) (a) To the extent funded, the department shall provide services to only blind or
834 disabled individuals, as defined in 42 U.S.C. Sec. 1382c(a)(1), who are 18 years old or older
835 and eligible for the program.

836 (b) Notwithstanding Subsection (2)(a), if a waiver is approved under Subsection (1)(b),
837 the department shall provide dental services to an individual who:

838 (i) qualifies for the health coverage improvement program described in Section
839 [26-18-411](#); and

840 (ii) is receiving treatment in a substance abuse treatment program, as defined in Section
841 [62A-2-101](#), licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

842 (c) To the extent possible, services to individuals described in Subsection (2)(a) within
843 Salt Lake County shall be provided through the University of Utah School of Dentistry.

844 (d) The department shall provide the services to individuals described in Subsection
845 (2)(b):

846 (i) by contracting with an entity that:

847 (A) has demonstrated experience working with individuals who are being treated for
848 both a substance use disorder and a major oral health disease;

849 (B) operates a program, targeted at the individuals described in Subsection (2)(b), that
850 has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental
851 treatment to those individuals described in Subsection (2)(b);

852 (C) is willing to pay for an amount equal to the program's non-federal share of the cost
853 of providing dental services to the population described in Subsection (2)(b); and

854 (D) is willing to pay all state costs associated with applying for the waiver described in
855 Subsection (1)(b) and administering the program described in Subsection (2)(b); and

856 (ii) through a fee-for-service payment model.

857 (e) The entity that receives the contract under Subsection (2)(d)(i) shall cover all state
858 costs of the program described in Subsection (2)(b).

859 (f) Each fiscal year, the University of Utah School of Dentistry shall transfer money to
860 the program in an amount equal to the program's non-federal share of the cost of providing
861 services under this section through the school during the fiscal year.

862 (g) During each general session of the Legislature, the department shall report to the
863 Social Services Appropriations Subcommittee whether the University of Utah School of
864 Dentistry will have sufficient funds to make the transfer required by Subsection (2)(f) for the
865 current fiscal year.

866 (h) Where possible, the department shall ensure that services that are not provided by
867 the University of Utah School of Dentistry are provided:

868 (i) through fee for service reimbursement until July 1, 2018; and

869 (ii) after July 1, 2018, through the method of reimbursement used by the division for

870 Medicaid dental benefits.

871 (i) Subject to appropriations by the Legislature, and as determined by the department,
872 the scope, amount, duration, and frequency of services may be limited.

873 (3) The reporting requirements of Section 26-18-3 apply to the waivers requested under
874 Subsection (1).

875 (4) (a) If the waivers requested under Subsection (1)(a) are granted, the Medicaid
876 program shall begin providing dental services in the manner described in Subsection (2) no
877 later than July 1, 2017.

878 (b) If the waivers requested under Subsection (1)(b) are granted, the Medicaid program
879 shall begin providing dental services to the population described in Subsection (2)(b) within 90
880 days from the day on which the waivers are granted.

881 (5) If the federal share of the cost of providing dental services under this section will be
882 less than 65% during any portion of the next fiscal year, the Medicaid program shall cease
883 providing dental services under this section no later than the end of the current fiscal year.

884 Section 17. Section 26-18-415 is amended to read:

885 **26-18-415. Medicaid waiver expansion.**

886 (1) As used in this section:

887 ~~[(a) "CMS" means the Centers for Medicare and Medicaid Services within the United
888 States Department of Health and Human Services.]~~

889 ~~[(b) "Expansion population" means individuals:]~~

890 ~~[(i) whose household income is less than 95% of the federal poverty level; and]~~

891 ~~[(ii) who are not eligible for enrollment in the Medicaid program, with the exception of
892 the Primary Care Network program, on May 8, 2018.]~~

893 ~~[(c)]~~ (a) "Federal poverty level" means the same as that term is defined in Section
894 26-18-411.

895 ~~[(d)]~~ (b) "Medicaid waiver expansion" means a Medicaid expansion in accordance with
896 this section.

897 (2) (a) Before January 1, 2019, the department shall apply to CMS for approval of a

898 waiver or state plan amendment to implement the Medicaid waiver expansion.

899 (b) The Medicaid waiver expansion shall:

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

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

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

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

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

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

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

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

916 (3) If the Medicaid waiver described in Subsection [~~(1)~~] (2)(a) is approved, the
917 department may only pay the state portion of costs for the Medicaid waiver expansion with
918 appropriations from:

919 (a) the Medicaid Expansion Fund, created in Section [26-36b-208](#);

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

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

923 (4) Medicaid accountable care organizations and counties that elect to integrate care
924 under Subsection (2)(b)(iv) shall collaborate on enrollment, engagement of patients, and
925 coordination of services.

926 (5) (a) If federal financial participation for the Medicaid waiver expansion is reduced
927 below 90%, the authority of the department to implement the Medicaid waiver expansion shall
928 sunset no later than the next July 1 after the date on which the federal financial participation is
929 reduced.

930 (b) The department shall close the program to new enrollment if the cost of the
931 Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are
932 authorized by the Legislature through an appropriations act adopted in accordance with Title
933 63J, Chapter 1, Budgetary Procedures Act.

934 (6) If the Medicaid waiver expansion is approved by CMS, the department shall report
935 to the Social Services Appropriations Subcommittee on or before November 1 of each year that
936 the Medicaid waiver expansion is operational:

- 937 (a) the number of individuals who enrolled in the Medicaid waiver program;
- 938 (b) costs to the state for the Medicaid waiver program;
- 939 (c) estimated costs for the current and following state fiscal year; and
- 940 (d) recommendations to control costs of the Medicaid waiver expansion.

941 Section 18. Section **26-18-416** is amended to read:

942 **26-18-416. Primary Care Network enhancement waiver program.**

943 (1) As used in this section:

944 [~~(a)~~] "~~CMS~~" means the Centers for Medicare and Medicaid Services within the United
945 States Department of Health and Human Services.]

946 [~~(b)~~] (a) "Enhancement waiver program" means the Primary Care Network
947 enhancement waiver program described in this section.

948 [~~(c)~~] (b) "Federal poverty level" means the poverty guidelines established by the
949 secretary of the United States Department of Health and Human Services under 42 U.S.C. Sec.
950 9902(2).

951 [~~(d)~~] (c) "Health coverage improvement program" means the same as that term is
952 defined in Section [26-18-411](#).

953 [~~(e)~~] (d) "Income eligibility ceiling" means the percentage of federal poverty level:

954 (i) established by the Legislature in an appropriations act adopted pursuant to Title 63J,
955 Chapter 1, Budgetary Procedures Act; and

956 (ii) under which an individual may qualify for coverage in the enhancement waiver
957 program in accordance with this section.

958 ~~[(f)]~~ (e) "Optional population" means the optional expansion population under PPACA
959 if the expansion provides coverage for individuals at or above 95% of the federal poverty level.

960 ~~[(g)] "PPACA" means the same as that term is defined in Section 31A-1-301.~~

961 ~~[(h)]~~ (f) "Primary Care Network" means the state Primary Care Network program
962 created by the Medicaid primary care network demonstration waiver obtained under Section
963 26-18-3.

964 (2) The department shall continue to implement the Primary Care Network program for
965 qualified individuals under the Primary Care Network program.

966 (3) (a) The division shall apply for a Medicaid waiver or a state plan amendment with
967 CMS to implement, within the state Medicaid program, the enhancement waiver program
968 described in this section within six months after the day on which:

969 (i) the division receives a notice from CMS that the waiver for the Medicaid waiver
970 expansion submitted under Section 26-18-415, Medicaid waiver expansion, will not be
971 approved; or

972 (ii) the division withdraws the waiver for the Medicaid waiver expansion submitted
973 under Section 26-18-415, Medicaid waiver expansion.

974 (b) The division may not apply for a waiver under Subsection (3)(a) while a waiver
975 request under Section 26-18-415, Medicaid waiver expansion, is pending with CMS.

976 (4) An individual who is eligible for the enhancement waiver program may receive the
977 following benefits under the enhancement waiver program:

978 (a) the benefits offered under the Primary Care Network program;

979 (b) diagnostic testing and procedures;

980 (c) medical specialty care;

981 (d) inpatient hospital services;

982 (e) outpatient hospital services;

983 (f) outpatient behavioral health care, including outpatient substance abuse care; and

984 (g) for an individual who qualifies for the health coverage improvement program, as

985 approved by CMS, temporary residential treatment for substance abuse in a short term,

986 non-institutional, 24-hour facility, without a bed capacity limit, that provides rehabilitation

987 services that are medically necessary and in accordance with an individualized treatment plan.

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

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

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

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

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

999 (i) adults in the expansion population, as defined in Section 26-18-411, who qualify for
1000 the health coverage improvement program;

1001 (ii) adults with dependent children who qualify for the health coverage improvement
1002 program under Subsection 26-18-411(3);

1003 (iii) adults with dependent children who do not qualify for the health coverage
1004 improvement program; and

1005 (iv) if funding is available, adults without dependent children.

1006 (b) The number of individuals enrolled in the enhancement waiver program may not
1007 exceed 105% of the number of individuals who were enrolled in the Primary Care Network on
1008 December 31, 2017.

1009 (c) The department may only use appropriations from the Medicaid Expansion Fund

1010 created in Section 26-36b-208 to fund the state portion of the enhancement waiver program.

1011 ~~[(d) The money deposited into the Medicaid Expansion Fund under Subsections~~
1012 ~~26-36b-208(g) and (h) may only be used to pay the cost of enrolling individuals who qualify for~~
1013 ~~the enhancement waiver program under Subsections (6)(a)(iii) and (iv).]~~

1014 (7) The department may request a modification of the income eligibility ceiling and the
1015 eligibility criteria under Subsection (6) from CMS each fiscal year based on enrollment in the
1016 enhancement waiver program, projected enrollment in the enhancement waiver program, costs
1017 to the state, and the state budget.

1018 (8) The department may implement the enhancement waiver program by contracting
1019 with Medicaid accountable care organizations to administer the enhancement waiver program.

1020 (9) In accordance with Subsections 26-18-411(11) and (12), the department may use
1021 funds that have been appropriated for the health coverage improvement program to implement
1022 the enhancement waiver program.

1023 (10) If the department expands the state Medicaid program to the optional population,
1024 the department:

1025 (a) except as provided in Subsection (11), may not accept any new enrollees into the
1026 enhancement waiver program after the day on which the expansion to the optional population
1027 is effective;

1028 (b) shall suspend the enhancement waiver program within one year after the day on
1029 which the expansion to the optional population is effective; and

1030 (c) shall work with CMS to maintain the waiver for the enhancement waiver program
1031 submitted under Subsection (3) while the enhancement waiver program is suspended under
1032 Subsection (10)(b).

1033 (11) If, after the expansion to the optional population described in Subsection (10)
1034 takes effect, the expansion to the optional population is repealed by either the state or the
1035 federal government, the department shall reinstate the enhancement waiver program and
1036 continue to accept new enrollees into the enhancement waiver program in accordance with the
1037 provisions of this section.

1038 Section 19. Section **26-18-417** is amended to read:

1039 **26-18-417. Limited family planning services for low-income individuals.**

1040 (1) As used in this section:

1041 (a) (i) "Family planning services" means family planning services that are provided
1042 under the state Medicaid program, including:

1043 (A) sexual health education and family planning counseling; and

1044 (B) other medical diagnosis, treatment, or preventative care routinely provided as part
1045 of a family planning service visit.

1046 (ii) "Family planning services" do not include an abortion, as that term is defined in
1047 Section [76-7-301](#).

1048 (b) "Low-income individual" means an individual who:

1049 (i) has an income level that is equal to or below 95% of the federal poverty level; and

1050 (ii) does not qualify for full coverage under the Medicaid program.

1051 (2) Before July 1, 2018, the division shall apply for a Medicaid waiver or a state plan
1052 amendment with [~~the Centers for Medicare and Medicaid Services within the United States~~
1053 ~~Department of Health and Human Services~~] CMS to:

1054 (a) offer a program that provides family planning services to low-income individuals;
1055 and

1056 (b) receive a federal match rate of 90% of state expenditures for family planning
1057 services provided under the waiver or state plan amendment.

1058 (3) If the waiver or state plan amendment described in Subsection (2) is approved, the
1059 department shall report to the Health and Human Services Interim Committee each year before
1060 November 30 while the waiver or state plan amendment is in effect regarding:

1061 (a) the number of qualified individuals served under the program;

1062 (b) the cost of the program; and

1063 (c) the effectiveness of the program, including:

1064 (i) any savings to the state Medicaid program from reductions in enrollment;

1065 (ii) any reduction in the number of abortions;

- 1066 (iii) any reduction in the number of unintended pregnancies;
 - 1067 (iv) any reduction in the number of individuals requiring services from the Women,
 - 1068 Infants, and Children Program established in 42 U.S.C. Sec. 1786; and
 - 1069 (v) any other costs and benefits as a result of the program.
- 1070 Section 20. Section **26-18-418** is amended to read:
- 1071 **26-18-418. Medicaid waiver for mental health crisis lines and mobile crisis**
- 1072 **outreach teams.**
- 1073 (1) As used in this section:
 - 1074 (a) "Local mental health crisis line" means the same as that term is defined in Section
 - 1075 [63C-18-102](#).
 - 1076 (b) "Mental health crisis" means:
 - 1077 (i) a mental health condition that manifests itself in an individual by symptoms of
 - 1078 sufficient severity that a prudent layperson who possesses an average knowledge of mental
 - 1079 health issues could reasonably expect the absence of immediate attention or intervention to
 - 1080 result in:
 - 1081 (A) serious danger to the individual's health or well-being; or
 - 1082 (B) a danger to the health or well-being of others; or
 - 1083 (ii) a mental health condition that, in the opinion of a mental health therapist or the
 - 1084 therapist's designee, requires direct professional observation or the intervention of a mental
 - 1085 health therapist.
 - 1086 (c) (i) "Mental health crisis services" means direct mental health services and on-site
 - 1087 intervention that a mobile crisis outreach team provides to an individual suffering from a
 - 1088 mental health crisis, including the provision of safety and care plans, prolonged mental health
 - 1089 services for up to 90 days, and referrals to other community resources.
 - 1090 (ii) "Mental health crisis services" includes:
 - 1091 (A) local mental health crisis lines; and
 - 1092 (B) the statewide mental health crisis line.
 - 1093 (d) "Mental health therapist" means the same as that term is defined in Section

1094 58-60-102.

1095 (e) "Mobile crisis outreach team" or "MCOT" means a mobile team of medical and
1096 mental health professionals that, in coordination with local law enforcement and emergency
1097 medical service personnel, provides mental health crisis services.

1098 (f) "Statewide mental health crisis line" means the same as that term is defined in
1099 Section 63C-18-102.

1100 (2) In consultation with the Department of Human Services and the Mental Health
1101 Crisis Line Commission created in Section 63C-18-202, the department shall develop a
1102 proposal to amend the state Medicaid plan to include mental health crisis services, including
1103 the statewide mental health crisis line, local mental health crisis lines, and mobile crisis
1104 outreach teams.

1105 (3) By January 1, 2019, the department shall apply for a Medicaid waiver with [~~the~~
1106 ~~Centers for Medicare and Medicaid Services within the United States Department of Health~~
1107 ~~and Human Services]~~ CMS, if necessary to implement, within the state Medicaid program, the
1108 mental health crisis services described in Subsection (2).

1109 Section 21. Section 26-18-501 is amended to read:

1110 **26-18-501. Definitions.**

1111 As used in this part:

1112 (1) "Certified program" means a nursing care facility program with Medicaid
1113 certification.

1114 (2) "Director" means the [~~director of the Division of Health Care Financing]~~ state
1115 Medicaid director appointed under Section 26-18-2.2.

1116 (3) "Medicaid certification" means the right of a nursing care facility, as a provider of a
1117 nursing care facility program, to receive Medicaid reimbursement for a specified number of
1118 beds within the facility.

1119 (4) (a) "Nursing care facility" means the following facilities licensed by the department
1120 under Chapter 21, Health Care Facility Licensing and Inspection Act:

1121 (i) skilled nursing facilities;

- 1122 (ii) intermediate care facilities; and
- 1123 (iii) an intermediate care facility for people with an intellectual disability.
- 1124 (b) "Nursing care facility" does not mean a critical access hospital that meets the
- 1125 criteria of 42 U.S.C. 1395i-4(c)(2) (1998).
- 1126 (5) "Nursing care facility program" means the personnel, licenses, services, contracts
- 1127 and all other requirements that shall be met for a nursing care facility to be eligible for
- 1128 Medicaid certification under this part and division rule.
- 1129 (6) "Physical facility" means the buildings or other physical structures where a nursing
- 1130 care facility program is operated.
- 1131 (7) "Rural county" means a county with a population of less than 50,000, as determined
- 1132 by:
- 1133 (a) the most recent official census or census estimate of the United States Bureau of
- 1134 the Census; or
- 1135 (b) the most recent population estimate for the county from the Utah Population
- 1136 Committee, if a population figure for the county is not available under Subsection (7)(a).
- 1137 (8) "Service area" means the boundaries of the distinct geographic area served by a
- 1138 certified program as determined by the division in accordance with this part and division rule.
- 1139 (9) "Urban county" means a county that is not a rural county.
- 1140 Section 22. Section **26-18-503** is amended to read:
- 1141 **26-18-503. Authorization to renew, transfer, or increase Medicaid certified**
- 1142 **programs -- Reimbursement methodology.**
- 1143 (1) (a) The division may renew Medicaid certification of a certified program if the
- 1144 program, without lapse in service to Medicaid recipients, has its nursing care facility program
- 1145 certified by the division at the same physical facility as long as the licensed and certified bed
- 1146 capacity at the facility has not been expanded, unless the director has approved additional beds
- 1147 in accordance with Subsection (5).
- 1148 (b) The division may renew Medicaid certification of a nursing care facility program
- 1149 that is not currently certified if:

1150 (i) since the day on which the program last operated with Medicaid certification:

1151 (A) the physical facility where the program operated has functioned solely and
1152 continuously as a nursing care facility; and

1153 (B) the owner of the program has not, under this section or Section 26-18-505,
1154 transferred to another nursing care facility program the license for any of the Medicaid beds in
1155 the program; and

1156 (ii) the number of beds granted renewed Medicaid certification does not exceed the
1157 number of beds certified at the time the program last operated with Medicaid certification,
1158 excluding a period of time where the program operated with temporary certification under
1159 Subsection 26-18-504~~(4)~~(3).

1160 (2) (a) The division may issue a Medicaid certification for a new nursing care facility
1161 program if a current owner of the Medicaid certified program transfers its ownership of the
1162 Medicaid certification to the new nursing care facility program and the new nursing care
1163 facility program meets all of the following conditions:

1164 (i) the new nursing care facility program operates at the same physical facility as the
1165 previous Medicaid certified program;

1166 (ii) the new nursing care facility program gives a written assurance to the director in
1167 accordance with Subsection (4);

1168 (iii) the new nursing care facility program receives the Medicaid certification within
1169 one year of the date the previously certified program ceased to provide medical assistance to a
1170 Medicaid recipient; and

1171 (iv) the licensed and certified bed capacity at the facility has not been expanded, unless
1172 the director has approved additional beds in accordance with Subsection (5).

1173 (b) A nursing care facility program that receives Medicaid certification under the
1174 provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing
1175 care facility program if the new nursing care facility program:

1176 (i) is not owned in whole or in part by the previous nursing care facility program; or

1177 (ii) is not a successor in interest of the previous nursing care facility program.

1178 (3) The division may issue a Medicaid certification to a nursing care facility program
1179 that was previously a certified program but now resides in a new or renovated physical facility
1180 if the nursing care facility program meets all of the following:

1181 (a) the nursing care facility program met all applicable requirements for Medicaid
1182 certification at the time of closure;

1183 (b) the new or renovated physical facility is in the same county or within a five-mile
1184 radius of the original physical facility;

1185 (c) the time between which the certified program ceased to operate in the original
1186 facility and will begin to operate in the new physical facility is not more than three years;

1187 (d) if Subsection (3)(c) applies, the certified program notifies the department within 90
1188 days after ceasing operations in its original facility, of its intent to retain its Medicaid
1189 certification;

1190 (e) the provider gives written assurance to the director in accordance with Subsection
1191 (4) that no third party has a legitimate claim to operate a certified program at the previous
1192 physical facility; and

1193 (f) the bed capacity in the physical facility has not been expanded unless the director
1194 has approved additional beds in accordance with Subsection (5).

1195 (4) (a) The entity requesting Medicaid certification under Subsections (2) and (3) shall
1196 give written assurances satisfactory to the director or the director's designee that:

1197 (i) no third party has a legitimate claim to operate the certified program;

1198 (ii) the requesting entity agrees to defend and indemnify the department against any
1199 claims by a third party who may assert a right to operate the certified program; and

1200 (iii) if a third party is found, by final agency action of the department after exhaustion
1201 of all administrative and judicial appeal rights, to be entitled to operate a certified program at
1202 the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

1203 (b) If a finding is made under the provisions of Subsection (4)(a)(iii):

1204 (i) the certified program shall immediately surrender its Medicaid certification and
1205 comply with division rules regarding billing for Medicaid and the provision of services to

1206 Medicaid patients; and

1207 (ii) the department shall transfer the surrendered Medicaid certification to the third
1208 party who prevailed under Subsection (4)(a)(iii).

1209 (5) (a) As provided in Subsection 26-18-502(2)(b), the director may approve additional
1210 nursing care facility programs for Medicaid certification, or additional beds for Medicaid
1211 certification within an existing nursing care facility program, if a nursing care facility or other
1212 interested party requests Medicaid certification for a nursing care facility program or additional
1213 beds within an existing nursing care facility program, and the nursing care facility program or
1214 other interested party complies with this section.

1215 (b) The nursing care facility or other interested party requesting Medicaid certification
1216 for a nursing care facility program or additional beds within an existing nursing care facility
1217 program under Subsection (5)(a) shall submit to the director:

1218 (i) proof of the following as reasonable evidence that bed capacity provided by
1219 Medicaid certified programs within the county or group of counties impacted by the requested
1220 additional Medicaid certification is insufficient:

1221 (A) nursing care facility occupancy levels for all existing and proposed facilities will
1222 be at least 90% for the next three years;

1223 (B) current nursing care facility occupancy is 90% or more; or

1224 (C) there is no other nursing care facility within a 35-mile radius of the nursing care
1225 facility requesting the additional certification; and

1226 (ii) an independent analysis demonstrating that at projected occupancy rates the nursing
1227 care facility's after-tax net income is sufficient for the facility to be financially viable.

1228 (c) Any request for additional beds as part of a renovation project are limited to the
1229 maximum number of beds allowed in Subsection (7).

1230 (d) The director shall determine whether to issue additional Medicaid certification by
1231 considering:

1232 (i) whether bed capacity provided by certified programs within the county or group of
1233 counties impacted by the requested additional Medicaid certification is insufficient, based on

1234 the information submitted to the director under Subsection (5)(b);

1235 (ii) whether the county or group of counties impacted by the requested additional

1236 Medicaid certification is underserved by specialized or unique services that would be provided

1237 by the nursing care facility;

1238 (iii) whether any Medicaid certified beds are subject to a claim by a previous certified

1239 program that may reopen under the provisions of Subsections (2) and (3);

1240 (iv) how additional bed capacity should be added to the long-term care delivery system

1241 to best meet the needs of Medicaid recipients; and

1242 (v) (A) whether the existing certified programs within the county or group of counties

1243 have provided services of sufficient quality to merit at least a two-star rating in the Medicare

1244 Five-Star Quality Rating System over the previous three-year period; and

1245 (B) information obtained under Subsection (9).

1246 (6) The department shall adopt administrative rules in accordance with Title 63G,

1247 Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility

1248 property reimbursement methodology to:

1249 (a) only pay that portion of the property component of rates, representing actual bed

1250 usage by Medicaid clients as a percentage of the greater of:

1251 (i) actual occupancy; or

1252 (ii) (A) for a nursing care facility other than a facility described in Subsection

1253 (6)(a)(ii)(B), 85% of total bed capacity; or

1254 (B) for a rural nursing care facility, 65% of total bed capacity; and

1255 (b) not allow for increases in reimbursement for property values without major

1256 renovation or replacement projects as defined by the department by rule.

1257 (7) (a) Notwithstanding Subsection 26-18-504~~(4)~~(3), if a nursing care facility does

1258 not seek Medicaid certification for a bed under Subsections (1) through (6), the department

1259 shall grant Medicaid certification for additional beds in an existing Medicaid certified nursing

1260 care facility that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility

1261 if:

1262 (i) the nursing care facility program was previously a certified program for all beds but
1263 now resides in a new facility or in a facility that underwent major renovations involving major
1264 structural changes, with 50% or greater facility square footage design changes, requiring review
1265 and approval by the department;

1266 (ii) the nursing care facility meets the quality of care regulations issued by [~~the Center~~
1267 ~~for Medicare and Medicaid Services~~] CMS; and

1268 (iii) the total number of additional beds in the facility granted Medicaid certification
1269 under this section does not exceed 10% of the number of licensed beds in the facility.

1270 (b) The department may not revoke the Medicaid certification of a bed under this
1271 Subsection (7) as long as the provisions of Subsection (7)(a)(ii) are met.

1272 (8) (a) If a nursing care facility or other interested party indicates in its request for
1273 additional Medicaid certification under Subsection (5)(a) that the facility will offer specialized
1274 or unique services, but the facility does not offer those services after receiving additional
1275 Medicaid certification, the director shall revoke the additional Medicaid certification.

1276 (b) The nursing care facility program shall obtain Medicaid certification for any
1277 additional Medicaid beds approved under Subsection (5) or (7) within three years of the date of
1278 the director's approval, or the approval is void.

1279 (9) (a) If the director makes an initial determination that quality standards under
1280 Subsection (5)(d)(v) have not been met in a rural county or group of rural counties over the
1281 previous three-year period, the director shall, before approving certification of additional
1282 Medicaid beds in the rural county or group of counties:

1283 (i) notify the certified program that has not met the quality standards in Subsection
1284 (5)(d)(v) that the director intends to certify additional Medicaid beds under the provisions of
1285 Subsection (5)(d)(v); and

1286 (ii) consider additional information submitted to the director by the certified program
1287 in a rural county that has not met the quality standards under Subsection (5)(d)(v).

1288 (b) The notice under Subsection (9)(a) does not give the certified program that has not
1289 met the quality standards under Subsection (5)(d)(v), the right to legally challenge or appeal the

1290 director's decision to certify additional Medicaid beds under Subsection (5)(d)(v).

1291 Section 23. Section **26-36b-202** is amended to read:

1292 **26-36b-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**

1293 (1) The collecting agent for the assessment imposed under Section **26-36b-201** is the
1294 department.

1295 (2) The department is vested with the administration and enforcement of this chapter,
1296 and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
1297 Act, necessary to:

1298 (a) collect the assessment, intergovernmental transfers, and penalties imposed under
1299 this chapter;

1300 (b) audit records of a facility that:

1301 (i) is subject to the assessment imposed by this chapter; and

1302 (ii) does not file a Medicare cost report; and

1303 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
1304 Medicare cost report.

1305 (3) The department shall:

1306 (a) administer the assessment in this chapter separately from the assessment in Chapter
1307 ~~[36a]~~ 36d, Hospital Provider Assessment Act; and

1308 (b) deposit assessments collected under this chapter into the Medicaid Expansion Fund
1309 created by Section **26-36b-208**.

1310 Section 24. Section **26-36b-208** is amended to read:

1311 **26-36b-208. Medicaid Expansion Fund.**

1312 (1) There is created an expendable special revenue fund known as the Medicaid
1313 Expansion Fund.

1314 (2) The fund consists of:

1315 (a) assessments collected under this chapter;

1316 (b) intergovernmental transfers under Section **26-36b-206**;

1317 (c) savings attributable to the health coverage improvement program as determined by

1318 the department;

1319 (d) savings attributable to the enhancement waiver program as determined by the
1320 department;

1321 (e) savings attributable to the Medicaid waiver expansion as determined by the
1322 department;

1323 (f) savings attributable to the inclusion of psychotropic drugs on the preferred drug list
1324 under Subsection 26-18-2.4(3) as determined by the department;

1325 [~~(g) savings attributable to the services provided by the Public Employees' Health Plan~~
1326 ~~under Subsection 49-20-401(1)(u);]~~

1327 [~~(h)~~] (g) gifts, grants, donations, or any other conveyance of money that may be made
1328 to the fund from private sources;

1329 [(~~i~~)] (h) interest earned on money in the fund; and

1330 [(~~j~~)] (i) additional amounts as appropriated by the Legislature.

1331 (3) (a) The fund shall earn interest.

1332 (b) All interest earned on fund money shall be deposited into the fund.

1333 (4) (a) A state agency administering the provisions of this chapter may use money from
1334 the fund to pay the costs, not otherwise paid for with federal funds or other revenue sources, of:

1335 (i) the health coverage improvement program;

1336 (ii) the enhancement waiver program;

1337 (iii) the Medicaid waiver expansion; and

1338 (iv) the outpatient upper payment limit supplemental payments under Section
1339 26-36b-210.

1340 (b) A state agency administering the provisions of this chapter may not use:

1341 (i) funds described in Subsection (2)(b) to pay the cost of private outpatient upper
1342 payment limit supplemental payments; or

1343 (ii) money in the fund for any purpose not described in Subsection (4)(a).

1344 Section 25. Section 26-36c-202 is amended to read:

1345 **26-36c-202. Collection of assessment -- Deposit of revenue -- Rulemaking.**

1346 (1) The department shall act as the collecting agent for the assessment imposed under
1347 Section 26-36c-201.

1348 (2) The department shall administer and enforce the provisions of this chapter, and may
1349 make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act,
1350 necessary to:

1351 (a) collect the assessment, intergovernmental transfers, and penalties imposed under
1352 this chapter;

1353 (b) audit records of a facility that:

1354 (i) is subject to the assessment imposed under this chapter; and

1355 (ii) does not file a Medicare cost report; and

1356 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
1357 Medicare cost report.

1358 (3) The department shall:

1359 (a) administer the assessment in this part separately from the assessments in Chapter
1360 [36a] 36d, Hospital Provider Assessment Act, and Chapter 36b, Inpatient Hospital Assessment
1361 Act; and

1362 (b) deposit assessments collected under this chapter into the Medicaid Expansion Fund.

1363 (4) (a) Hospitals shall pay the quarterly assessments imposed by this chapter to the
1364 division within 15 business days after the original invoice date that appears on the invoice
1365 issued by the division.

1366 (b) The department may make rules creating requirements to allow the time for paying
1367 the assessment to be extended.

1368 Section 26. Section 26-40-102 is amended to read:

1369 **26-40-102. Definitions.**

1370 As used in this chapter:

1371 (1) "Child" means a person who is under 19 years of age.

1372 (2) "Eligible child" means a child who qualifies for enrollment in the program as
1373 provided in Section 26-40-105.

1374 (3) [~~Enrollee~~] Member means [~~any~~] a child enrolled in the program.

1375 (4) "Plan" means the department's plan submitted to the United States Department of
1376 Health and Human Services pursuant to 42 U.S.C. Sec. 1397ff.

1377 (5) "Program" means the Utah Children's Health Insurance Program created by this
1378 chapter.

1379 Section 27. Section **26-40-103** is amended to read:

1380 **26-40-103. Creation and administration of the Utah Children's Health Insurance**
1381 **Program.**

1382 (1) There is created the Utah Children's Health Insurance Program to be administered
1383 by the department in accordance with the provisions of:

1384 (a) this chapter; and

1385 (b) the State Children's Health Insurance Program, 42 U.S.C. Sec. 1397aa et seq.

1386 (2) The department shall:

1387 (a) prepare and submit the state's children's health insurance plan before May 1, 1998,
1388 and any amendments to the federal Department of Health and Human Services in accordance
1389 with 42 U.S.C. Sec. 1397ff; and

1390 (b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
1391 Rulemaking Act regarding:

1392 (i) eligibility requirements consistent with Section [26-18-3](#);

1393 (ii) program benefits;

1394 (iii) the level of coverage for each program benefit;

1395 (iv) cost-sharing requirements for [~~enrollees~~] members, which may not:

1396 (A) exceed the guidelines set forth in 42 U.S.C. Sec. 1397ee; or

1397 (B) impose deductible, copayment, or coinsurance requirements on [~~an enrollee~~] a
1398 member for well-child, well-baby, and immunizations;

1399 (v) the administration of the program; and

1400 (vi) a requirement that:

1401 (A) [~~enrollees~~] members in the program shall participate in the electronic exchange of

1402 clinical health records established in accordance with Section 26-1-37 unless the [enrollee]
1403 member opts out of participation;

1404 (B) prior to enrollment in the electronic exchange of clinical health records the
1405 [enrollee] member shall receive notice of the enrollment in the electronic exchange of clinical
1406 health records and the right to opt out of participation at any time; and

1407 (C) beginning July 1, 2012, when the program sends enrollment or renewal information
1408 to the [enrollee] member and when the [enrollee] member logs onto the program's website, the
1409 [enrollee] member shall receive notice of the right to opt out of the electronic exchange of
1410 clinical health records.

1411 Section 28. Section **26-40-105** is amended to read:

1412 **26-40-105. Eligibility.**

1413 (1) A child is eligible to enroll in the program if the child:

1414 (a) is a bona fide Utah resident;

1415 (b) is a citizen or legal resident of the United States;

1416 (c) is under 19 years of age;

1417 (d) does not have access to or coverage under other health insurance, including any
1418 coverage available through a parent or legal guardian's employer;

1419 (e) is ineligible for Medicaid benefits;

1420 (f) resides in a household whose gross family income, as defined by rule, is at or below
1421 200% of the federal poverty level; and

1422 (g) is not an inmate of a public institution or a patient in an institution for mental
1423 diseases.

1424 (2) A child who qualifies for enrollment in the program under Subsection (1) may not
1425 be denied enrollment due to a diagnosis or pre-existing condition.

1426 (3) (a) The department shall determine eligibility and send notification of the eligibility
1427 decision within 30 days after receiving the application for coverage.

1428 (b) If the department cannot reach a decision because the applicant fails to take a
1429 required action, or because there is an administrative or other emergency beyond the

1430 department's control, the department shall:

1431 (i) document the reason for the delay in the applicant's case record; and

1432 (ii) inform the applicant of the status of the application and time frame for completion.

1433 (4) The department may not close enrollment in the program for a child who is eligible

1434 to enroll in the program under the provisions of Subsection (1).

1435 (5) ~~(a)~~ The program shall:

1436 ~~(i)~~ (a) apply for grants to make technology system improvements necessary to

1437 implement a simplified enrollment and renewal process in accordance with ~~[this]~~ Subsection

1438 ~~(5)(b)~~; and

1439 ~~(ii)~~ (b) if funding is available, implement ~~[the]~~ a simplified enrollment and renewal

1440 process ~~[in accordance with this Subsection (5)]~~.

1441 ~~[(b) The simplified enrollment and renewal process:]~~

1442 ~~[(i) shall, in accordance with Section 59-1-403, provide an eligibility worker a process~~

1443 ~~in which the eligibility worker:]~~

1444 ~~[(A) verifies the applicant's identity;]~~

1445 ~~[(B) gets consent to obtain the applicant's adjusted gross income from the State Tax~~

1446 ~~Commission from:]~~

1447 ~~[(F) the applicant, if the applicant filed a single tax return; or]~~

1448 ~~[(H) both parties to a joint return, if the applicant filed a joint tax return; and]~~

1449 ~~[(C) obtains from the Utah State Tax Commission, the adjusted gross income of the~~

1450 ~~applicant; and]~~

1451 ~~[(ii) may not change the eligibility requirements for the program:]~~

1452 Section 29. Section **26-40-106** is amended to read:

1453 **26-40-106. Program benefits.**

1454 (1) Except as provided in Subsection ~~[(4)]~~ (3), medical and dental program benefits

1455 shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, ~~[to be actuarially equivalent]~~

1456 as follows:

1457 (a) medical program benefits, including behavioral health care benefits, shall be

1458 benchmarked on July 1, 2019, and on July 1 every third year thereafter, to:

1459 (i) be substantially equal to a health benefit plan with the largest insured commercial
1460 enrollment offered by a health maintenance organization in the state[-]; and

1461 (ii) comply with the Mental Health Parity and Addiction Equity Act, Pub. L. No.
1462 110-343; and

1463 [~~(2) Except as provided in Subsection (4):]~~

1464 [~~(a) medical program benefits may not exceed the benefit level described in Subsection~~
1465 ~~(1); and]~~

1466 [~~(b) medical program benefits shall be adjusted every July 1 to meet the benefit level~~
1467 ~~described in Subsection (1):]~~

1468 [~~(3) The dental benefit plan shall be benchmarked;]~~

1469 (b) dental program benefits shall be benchmarked on July 1, 2019, and on July 1 every
1470 third year thereafter in accordance with the Children's Health Insurance Program

1471 Reauthorization Act of 2009, to be [~~equivalent~~] substantially equal to a dental benefit plan that
1472 has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in
1473 the state, except that the utilization review mechanism for orthodontia shall be based on
1474 medical necessity. [~~Dental program benefits shall be adjusted on July 1, 2012, and on July 1~~
1475 ~~every three years thereafter to meet the benefit level required by this Subsection (3):]~~

1476 (2) On or before January 31 of each year, the department shall publish the benchmark
1477 for dental program benefits established under Subsection (1)(b).

1478 [~~(4)~~] (3) The program benefits for enrollees who are at or below 100% of the federal
1479 poverty level are exempt from the benchmark requirements of Subsections (1) and (2).

1480 Section 30. Section **26-40-110** is amended to read:

1481 **26-40-110. Managed care -- Contracting for services.**

1482 (1) Program benefits provided to [~~enrollees~~] a member under the program, as described
1483 in Section **26-40-106**, shall be delivered by a managed care organization if the department
1484 determines that adequate services are available where the [~~enrollee~~] member lives or resides.

1485 (2) The department may contract with a managed care organization to provide program

1486 benefits. The department shall ~~[use the following criteria to]~~ evaluate a potential contract with
1487 a managed care organization based on:

1488 (a) the managed care organization's:

1489 (i) ability to manage medical expenses, including mental health costs;

1490 (ii) proven ability to handle accident and health insurance;

1491 (iii) efficiency of claim paying procedures;

1492 (iv) proven ability for managed care and quality assurance;

1493 (v) provider contracting and discounts;

1494 (vi) pharmacy benefit management;

1495 (vii) estimated total charges for administering the pool;

1496 (viii) ability to administer the pool in a cost-efficient manner;

1497 (ix) ability to provide adequate providers and services in the state; and

1498 (x) ability to meet quality measures for emergency room use and access to primary care
1499 established by the department under Subsection [26-18-408\(4\)](#); and

1500 (b) other ~~[criteria]~~ factors established by the department.

1501 (3) The department may enter into separate managed care organization contracts to
1502 provide dental benefits required by Section [26-40-106](#).

1503 (4) The department's contract with a ~~[health or dental plan]~~ managed care organization
1504 for the program's benefits shall include risk sharing provisions in which the plan shall accept at
1505 least 75% of the risk for any difference between the department's premium payments per
1506 ~~[client]~~ member and actual medical expenditures.

1507 (5) (a) The department may contract with the Group Insurance Division within the
1508 Utah State Retirement Office to provide services under Subsection (1) if no ~~[other health or~~
1509 ~~dental plan]~~ managed care organization is willing to contract with the department or the
1510 department determines no ~~[other plan]~~ managed care organization meets the criteria established
1511 under Subsection (2).

1512 (b) In accordance with Section [49-20-201](#), a contract awarded under Subsection (5)(a)
1513 is not subject to the risk sharing required by Subsection (4).

1514 Section 31. Section **26-40-115** is amended to read:

1515 **26-40-115. State contractor -- Employee and dependent health benefit plan**
1516 **coverage.**

1517 (1) For purposes of Sections [17B-2a-818.5](#), [19-1-206](#), [63A-5-205.5](#), [63C-9-403](#),
1518 [72-6-107.5](#), and [79-2-404](#), "qualified health insurance coverage" means, at the time the contract
1519 is entered into or renewed:

1520 (a) a health benefit plan and employer contribution level with a combined actuarial
1521 value at least actuarially equivalent to the combined actuarial value of the benchmark plan
1522 determined by the program under Subsection [26-40-106\(1\)\(a\)](#), and a contribution level at
1523 which the employer pays at least 50% of the premium for the employee and the dependents of
1524 the employee who reside or work in the state; or

1525 (b) a federally qualified high deductible health plan that, at a minimum:

1526 (i) has a deductible that is:

1527 (A) the lowest deductible permitted for a federally qualified high deductible health
1528 plan; or

1529 (B) a deductible that is higher than the lowest deductible permitted for a federally
1530 qualified high deductible health plan, but includes an employer contribution to a health savings
1531 account in a dollar amount at least equal to the dollar amount difference between the lowest
1532 deductible permitted for a federally qualified high deductible plan and the deductible for the
1533 employer offered federally qualified high deductible plan;

1534 (ii) has an out-of-pocket maximum that does not exceed three times the amount of the
1535 annual deductible; and

1536 (iii) provides that the employer pays 60% of the premium for the employee and the
1537 dependents of the employee who work or reside in the state.

1538 (2) The department shall:

1539 (a) on or before July 1, 2016:

1540 (i) determine the commercial equivalent of the benchmark plan described in Subsection
1541 (1)(a); and

1542 (ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i)
1543 on the department's website, noting the date posted; and

1544 (b) update the posted commercially equivalent benchmark plan annually and at the
1545 time of any change in the benchmark.

1546 Section 32. Section **26-40-116** is amended to read:

1547 **26-40-116. Program to encourage appropriate emergency room use -- Application**
1548 **for waivers.**

1549 The program is subject to the provisions of Section **26-18-408** and shall apply for
1550 waivers in accordance with Subsection **26-18-408**~~(5)~~(4)(c).

1551 Section 33. Section **49-20-401** is amended to read:

1552 **49-20-401. Program -- Powers and duties.**

1553 (1) The program shall:

1554 (a) act as a self-insurer of employee benefit plans and administer those plans;

1555 (b) enter into contracts with private insurers or carriers to underwrite employee benefit
1556 plans as considered appropriate by the program;

1557 (c) indemnify employee benefit plans or purchase commercial reinsurance as
1558 considered appropriate by the program;

1559 (d) provide descriptions of all employee benefit plans under this chapter in cooperation
1560 with covered employers;

1561 (e) process claims for all employee benefit plans under this chapter or enter into
1562 contracts, after competitive bids are taken, with other benefit administrators to provide for the
1563 administration of the claims process;

1564 (f) obtain an annual actuarial review of all health and dental benefit plans and a
1565 periodic review of all other employee benefit plans;

1566 (g) consult with the covered employers to evaluate employee benefit plans and develop
1567 recommendations for benefit changes;

1568 (h) annually submit a budget and audited financial statements to the governor and
1569 Legislature which includes total projected benefit costs and administrative costs;

- 1570 (i) maintain reserves sufficient to liquidate the unrevealed claims liability and other
- 1571 liabilities of the employee benefit plans as certified by the program's consulting actuary;
- 1572 (j) submit, in advance, its recommended benefit adjustments for state employees to:
- 1573 (i) the Legislature; and
- 1574 (ii) the executive director of the state Department of Human Resource Management;
- 1575 (k) determine benefits and rates, upon approval of the board, for [~~multiemployer~~]
- 1576 multi-employer risk pools, retiree coverage, and conversion coverage;
- 1577 (l) determine benefits and rates based on the total estimated costs and the employee
- 1578 premium share established by the Legislature, upon approval of the board, for state employees;
- 1579 (m) administer benefits and rates, upon ratification of the board, for [~~single-employer~~]
- 1580 single-employer risk pools;
- 1581 (n) request proposals for provider networks or health and dental benefit plans
- 1582 administered by [~~third-party~~] third-party carriers at least once every three years for the purposes
- 1583 of:
- 1584 (i) stimulating competition for the benefit of covered individuals;
- 1585 (ii) establishing better geographical distribution of medical care services; and
- 1586 (iii) providing coverage for both active and retired covered individuals;
- 1587 (o) offer proposals which meet the criteria specified in a request for proposals and
- 1588 accepted by the program to active and retired state covered individuals and which may be
- 1589 offered to active and retired covered individuals of other covered employers at the option of the
- 1590 covered employer;
- 1591 (p) perform the same functions established in Subsections (1)(a), (b), (e), and (h) for
- 1592 the Department of Health if the program provides program benefits to children enrolled in the
- 1593 Utah Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's
- 1594 Health Insurance Act;
- 1595 (q) establish rules and procedures governing the admission of political subdivisions or
- 1596 educational institutions and their employees to the program;
- 1597 (r) contract directly with medical providers to provide services for covered individuals;

1598 (s) take additional actions necessary or appropriate to carry out the purposes of this
1599 chapter;

1600 (t) (i) require state employees and their dependents to participate in the electronic
1601 exchange of clinical health records in accordance with Section 26-1-37 unless the enrollee opts
1602 out of participation; and

1603 (ii) prior to enrolling the state employee, each time the state employee logs onto the
1604 program's website, and each time the enrollee receives written enrollment information from the
1605 program, provide notice to the enrollee of the enrollee's participation in the electronic exchange
1606 of clinical health records and the option to opt out of participation at any time; and

1607 (u) [~~provide services for drugs or medical devices~~] at the request of a procurement unit,
1608 as that term is defined in Section 63G-6a-103, that administers benefits to program recipients
1609 who are not covered by Title 26, Utah Health Code[-], provide services for:

1610 (i) drugs;

1611 (ii) medical devices; or

1612 (iii) other types of medical care.

1613 (2) (a) Funds budgeted and expended shall accrue from rates paid by the covered
1614 employers and covered individuals.

1615 (b) Administrative costs shall be approved by the board and reported to the governor
1616 and the Legislature.

1617 (3) The Department of Human Resource Management shall include the benefit
1618 adjustments described in Subsection (1)(j) in the total compensation plan recommended to the
1619 governor required under Subsection 67-19-12(5)(a).

1620 Section 34. Section 58-60-205 is amended to read:

1621 **58-60-205. Qualifications for licensure or certification as a clinical social worker,**
1622 **certified social worker, and social service worker.**

1623 (1) An applicant for licensure as a clinical social worker shall:

1624 (a) submit an application on a form provided by the division;

1625 (b) pay a fee determined by the department under Section 63J-1-504;

1626 (c) be of good moral character;

1627 (d) produce certified transcripts from an accredited institution of higher education

1628 recognized by the division in collaboration with the board verifying satisfactory completion of

1629 an education and an earned degree as follows:

1630 (i) a master's degree in a social work program accredited by the Council on Social

1631 Work Education or by the Canadian Association of Schools of Social Work; or

1632 (ii) a doctoral degree that contains a clinical social work concentration and practicum

1633 approved by the division, by rule, in accordance with Title 63G, Chapter 3, Utah

1634 Administrative Rulemaking Act, that is consistent with Section 58-1-203;

1635 (e) have completed a minimum of 4,000 hours of clinical social work training as

1636 defined by division rule under Section 58-1-203:

1637 (i) in not less than two years;

1638 (ii) under the supervision of a ~~clinical social worker~~ supervisor approved by the

1639 division in collaboration with the board who is a:

1640 (A) clinical mental health counselor;

1641 (B) psychiatrist;

1642 (C) psychologist;

1643 (D) registered psychiatric mental health nurse practitioner;

1644 (E) marriage and family therapist; or

1645 (F) clinical social worker; and

1646 (iii) including a minimum of two hours of training in suicide prevention via a course

1647 that the division designates as approved;

1648 (f) document successful completion of not less than 1,000 hours of supervised training

1649 in mental health therapy obtained after completion of the education requirement in Subsection

1650 (1)(d), which training may be included as part of the 4,000 hours of training in Subsection

1651 (1)(e), and of which documented evidence demonstrates not less than 100 of the hours were

1652 obtained under the direct supervision ~~[of a clinical social worker]~~, as defined by rule, of a

1653 supervisor described in Subsection (1)(e)(ii);

1654 (g) have completed a case work, group work, or family treatment course sequence with
1655 a clinical practicum in content as defined by rule under Section 58-1-203; and

1656 (h) pass the examination requirement established by rule under Section 58-1-203.

1657 (2) An applicant for licensure as a certified social worker shall:

1658 (a) submit an application on a form provided by the division;

1659 (b) pay a fee determined by the department under Section 63J-1-504;

1660 (c) be of good moral character;

1661 (d) produce certified transcripts from an accredited institution of higher education
1662 recognized by the division in collaboration with the board verifying satisfactory completion of
1663 an education and an earned degree as follows:

1664 (i) a master's degree in a social work program accredited by the Council on Social
1665 Work Education or by the Canadian Association of Schools of Social Work; or

1666 (ii) a doctoral degree that contains a clinical social work concentration and practicum
1667 approved by the division, by rule, in accordance with Title 63G, Chapter 3, Utah
1668 Administrative Rulemaking Act, that is consistent with Section 58-1-203; and

1669 (e) pass the examination requirement established by rule under Section 58-1-203.

1670 (3) (a) An applicant for certification as a certified social worker intern shall meet the
1671 requirements of Subsections (2)(a), (b), (c), and (d).

1672 (b) Certification under Subsection (3)(a) is limited to the time necessary to pass the
1673 examination required under Subsection (2)(e) or six months, whichever occurs first.

1674 (c) A certified social worker intern may provide mental health therapy under the
1675 general supervision [~~of a clinical social worker~~], as defined by rule, of a supervisor described in
1676 Subsection (1)(e)(ii).

1677 (4) An applicant for licensure as a social service worker shall:

1678 (a) submit an application on a form provided by the division;

1679 (b) pay a fee determined by the department under Section 63J-1-504;

1680 (c) be of good moral character;

1681 (d) produce certified transcripts from an accredited institution of higher education

1682 recognized by the division in collaboration with the board verifying satisfactory completion of
1683 an education and an earned degree as follows:

1684 (i) a bachelor's degree in a social work program accredited by the Council on Social
1685 Work Education or by the Canadian Association of Schools of Social Work;

1686 (ii) a master's degree in a field approved by the division in collaboration with the
1687 board;

1688 (iii) a bachelor's degree in any field if the applicant:

1689 (A) has completed at least three semester hours, or the equivalent, in each of the
1690 following areas:

1691 (I) social welfare policy;

1692 (II) human growth and development; and

1693 (III) social work practice methods, as defined by rule; and

1694 (B) provides documentation that the applicant has completed at least 2,000 hours of
1695 qualifying experience under the supervision of a mental health therapist, which experience is
1696 approved by the division in collaboration with the board, and which is performed after
1697 completion of the requirements to obtain the bachelor's degree required under this Subsection
1698 (4); or

1699 (iv) successful completion of the first academic year of a Council on Social Work
1700 Education approved master's of social work curriculum and practicum; and

1701 (e) pass the examination requirement established by rule under Section [58-1-203](#).

1702 (5) The division shall ensure that the rules for an examination described under
1703 Subsections (1)(h), (2)(e), and (4)(e) allow additional time to complete the examination if
1704 requested by an applicant who is:

1705 (a) a foreign born legal resident of the United States for whom English is a second
1706 language; or

1707 (b) an enrolled member of a federally recognized Native American tribe.

1708 Section 35. Section **58-60-207** is amended to read:

1709 **58-60-207. Scope of practice -- Limitations.**

1710 (1) (a) A clinical social worker may engage in all acts and practices defined as the
1711 practice of clinical social work without supervision, in private and independent practice, or as
1712 an employee of another person, limited only by the licensee's education, training, and
1713 competence.

1714 (b) A clinical social worker may not supervise more than six individuals who are
1715 lawfully engaged in training for the practice of mental health therapy, unless granted an
1716 exception in writing from the division in collaboration with the board.

1717 (2) To the extent an individual is professionally prepared by the education and training
1718 track completed while earning a master's or doctor of social work degree, a licensed certified
1719 social worker may engage in all acts and practices defined as the practice of certified social
1720 work consistent with the licensee's education, clinical training, experience, and competence:

1721 (a) under supervision of [~~a clinical social worker~~] an individual described in
1722 Subsection 58-60-205(1)(e)(ii) and as an employee of another person when engaged in the
1723 practice of mental health therapy;

1724 (b) without supervision and in private and independent practice or as an employee of
1725 another person, if not engaged in the practice of mental health therapy;

1726 (c) including engaging in the private, independent, unsupervised practice of social
1727 work as a self-employed individual, in partnership with other [~~licensed clinical or certified~~
1728 ~~social workers~~] mental health therapists, as a professional corporation, or in any other capacity
1729 or business entity, so long as he does not practice unsupervised psychotherapy; and

1730 (d) supervising social service workers as provided by division rule.

1731 Section 36. Section **58-60-305** is amended to read:

1732 **58-60-305. Qualifications for licensure.**

1733 (1) All applicants for licensure as marriage and family therapists shall:

1734 (a) submit an application on a form provided by the division;

1735 (b) pay a fee determined by the department under Section [63J-1-504](#);

1736 (c) be of good moral character;

1737 (d) produce certified transcripts evidencing completion of a masters or doctorate degree

1738 in marriage and family therapy from:

1739 (i) a program accredited by the Commission on Accreditation for Marriage and Family
1740 Therapy Education; or

1741 (ii) an accredited institution meeting criteria for approval established by rule under
1742 Section 58-1-203;

1743 (e) have completed a minimum of 4,000 hours of marriage and family therapy training
1744 as defined by division rule under Section 58-1-203:

1745 (i) in not less than two years;

1746 (ii) under the supervision of a [~~marriage and family~~] mental health therapist supervisor
1747 who meets the requirements of Section 58-60-307;

1748 (iii) obtained after completion of the education requirement in Subsection (1)(d); and

1749 (iv) including a minimum of two hours of training in suicide prevention via a course
1750 that the division designates as approved;

1751 (f) document successful completion of not less than 1,000 hours of supervised training
1752 in mental health therapy obtained after completion of the education requirement described in
1753 Subsection (1)(d)(i) or (1)(d)(ii), which training may be included as part of the 4,000 hours of
1754 training described in Subsection (1)(e), and of which documented evidence demonstrates not
1755 less than 100 of the supervised hours were obtained during direct, personal supervision, as
1756 defined by rule, by a [~~marriage and family~~] mental health therapist supervisor qualified under
1757 Section 58-60-307[~~, as defined by rule~~]; and

1758 (g) pass the examination requirement established by division rule under Section
1759 58-1-203.

1760 (2) (a) All applicants for licensure as an associate marriage and family therapist shall
1761 comply with the provisions of Subsections (1)(a), (b), (c), and (d).

1762 (b) An individual's license as an associate marriage and family therapist is limited to
1763 the period of time necessary to complete clinical training as described in Subsections (1)(e) and
1764 (f) and extends not more than one year from the date the minimum requirement for training is
1765 completed, unless the individual presents satisfactory evidence to the division and the

1766 appropriate board that the individual is making reasonable progress toward passing of the
1767 qualifying examination for that profession or is otherwise on a course reasonably expected to
1768 lead to licensure, but the period of time under this Subsection (2)(b) may not exceed two years
1769 past the date the minimum supervised clinical training requirement has been completed.

1770 Section 37. Section **58-60-307** is amended to read:

1771 **58-60-307. Supervisors of marriage and family therapists -- Qualifications.**

1772 (1) Each person acting as a supervisor of a marriage and family therapist [~~supervisor~~]
1773 shall:

1774 (a) have at least two years of clinical experience [~~as a marriage and family therapist~~],
1775 since the date of first licensure, as a [~~marriage and family therapist; and~~]:

1776 (i) clinical mental health counselor;

1777 (ii) psychiatrist;

1778 (iii) psychologist;

1779 (iv) registered psychiatric mental health nurse practitioner;

1780 (v) marriage and family therapist; or

1781 (vi) clinical social worker;

1782 (b) either:

1783 (i) be approved as a supervisor by a national marriage and family therapist professional
1784 organization; or

1785 (ii) meet the criteria established by rule[-]; and

1786 (c) provide supervision for no more than six individuals who are lawfully engaged in
1787 training for the practice of mental health therapy, unless granted an exception in writing from
1788 the division in collaboration with the board.

1789 (2) Persons who act as a supervisor without meeting the requirements of this section
1790 are subject to discipline for unprofessional conduct.

1791 Section 38. Section **58-60-308** is amended to read:

1792 **58-60-308. Scope of practice -- Limitations.**

1793 (1) A licensed marriage and family therapist may engage in all acts and practices

1794 defined as the practice of marriage and family therapy without supervision, in private and
1795 independent practice, or as an employee of another person, limited only by the licensee's
1796 education, training, and competence.

1797 (2) (a) To the extent an individual has completed the educational requirements of
1798 Subsection 58-60-305(1)(d), a licensed associate marriage and family therapist may engage in
1799 all acts and practices defined as the practice of marriage and family therapy if the practice is:

1800 (i) within the scope of employment as a licensed associate marriage and family
1801 therapist with a public agency or a private clinic as defined by division rule; and

1802 (ii) under the supervision of a licensed [~~marriage and family~~] mental health therapist
1803 who is qualified as a supervisor under Section 58-60-307.

1804 (b) A licensed associate marriage and family therapist may not engage in the
1805 independent practice of marriage and family therapy.

1806 Section 39. Section 58-60-407 is amended to read:

1807 **58-60-407. Scope of practice -- Limitations.**

1808 (1) (a) A licensed clinical mental health counselor may engage in all acts and practices
1809 defined as the practice of clinical mental health counseling without supervision, in private and
1810 independent practice, or as an employee of another person, limited only by the licensee's
1811 education, training, and competence.

1812 (b) A licensed clinical mental health counselor may not supervise more than six
1813 individuals who are lawfully engaged in training for the practice of mental health therapy,
1814 unless granted an exception in writing from the division in collaboration with the board.

1815 (2) (a) To the extent an individual has completed the educational requirements of
1816 Subsection 58-60-305(1)(d), a licensed associate clinical mental health counselor may engage
1817 in all acts and practices defined as the practice of clinical mental health counseling if the
1818 practice is:

1819 (i) within the scope of employment as a licensed clinical mental health counselor with
1820 a public agency or private clinic as defined by division rule; and

1821 (ii) under supervision of a qualified licensed mental health therapist as defined in

1822 Section 58-60-102.

1823 (b) A licensed associate clinical mental health counselor may not engage in the
1824 independent practice of clinical mental health counseling.

1825 Section 40. Section 58-60-502 is amended to read:

1826 **58-60-502. Definitions.**

1827 In addition to the definitions in Sections 58-1-102 and 58-60-102, as used in this part:

1828 (1) "Board" means the Substance Use Disorder Counselor Licensing Board created in
1829 Section 58-60-503.

1830 (2) (a) "Counseling" means a collaborative process that facilitates the client's progress
1831 toward mutually determined treatment goals and objectives.

1832 (b) "Counseling" includes:

1833 (i) methods that are sensitive to an individual client's characteristics, to the influence of
1834 significant others, and to the client's cultural and social context; and

1835 (ii) an understanding, appreciation, and ability to appropriately use the contributions of
1836 various addiction counseling models as the counseling models apply to modalities of care for
1837 individuals, groups, families, couples, and significant others.

1838 (3) "Direct supervision" means:

1839 (a) a minimum of one hour of supervision by a supervisor of the substance use disorder
1840 counselor for every 40 hours of client care provided by the substance use disorder counselor,
1841 which supervision may include group supervision;

1842 (b) the supervision is conducted in a face-to-face manner, unless otherwise approved
1843 on a case-by-case basis by the division in collaboration with the board; and

1844 (c) a supervisor is available for consultation with the counselor at all times.

1845 (4) "General supervision" shall be defined by division rule.

1846 (5) "Group supervision" means more than one counselor licensed under this part meets
1847 with the supervisor at the same time.

1848 (6) "Individual supervision" means only one counselor licensed under this part meets
1849 with the supervisor at a given time.

1850 (7) "Practice as a certified advanced substance use disorder counselor" and "practice as
1851 a certified advanced substance use disorder counselor intern" means providing services
1852 described in Subsection (9) under the direct supervision of a mental health therapist or licensed
1853 advanced substance use disorder counselor.

1854 (8) "Practice as a certified substance use disorder counselor" and "practice as a certified
1855 substance use disorder counselor intern" means providing the services described in Subsections
1856 (10)(a) and (b) under the direct supervision of a mental health therapist or licensed advanced
1857 substance use disorder counselor.

1858 (9) "Practice as a licensed advanced substance use disorder counselor" means:

1859 (a) providing the services described in Subsections (10)(a) and (b);

1860 (b) screening and assessing of individuals, including identifying substance use disorder
1861 symptoms and behaviors and co-occurring mental health issues; ~~and~~

1862 (c) treatment planning for substance use disorders, including initial planning, ongoing
1863 intervention, continuity of care, discharge planning, planning for relapse prevention, and long
1864 term recovery support~~[-]; and~~

1865 (d) supervising a certified substance use disorder counselor, certified substance use
1866 disorder counselor intern, certified advanced substance use disorder counselor, certified
1867 advanced substance use disorder counselor intern, or licensed substance use disorder counselor
1868 in accordance with Subsection 58-60-508(2).

1869 (10) (a) "Practice as a substance use disorder counselor" means providing services as
1870 an employee of a substance use disorder agency under the general supervision of a licensed
1871 mental health therapist to individuals or groups of persons, whether in person or remotely, for
1872 conditions of substance use disorders consistent with the education and training of a substance
1873 use disorder counselor required under this part, and the standards and ethics of the profession
1874 as approved by the division in collaboration with the board.

1875 (b) "Practice as a substance use disorder counselor" includes:

1876 (i) administering the screening process by which a client is determined to need
1877 substance use disorder services, which may include screening, brief intervention, and treatment

- 1878 referral;
- 1879 (ii) conducting the administrative intake procedures for admission to a program;
- 1880 (iii) conducting orientation of a client, including:
- 1881 (A) describing the general nature and goals of the program;
- 1882 (B) explaining rules governing client conduct and infractions that can lead to
- 1883 disciplinary action or discharge from the program;
- 1884 (C) explaining hours during which services are available in a nonresidential program;
- 1885 (D) treatment costs to be borne by the client, if any; and
- 1886 (E) describing the client's rights as a program participant;
- 1887 (iv) conducting assessment procedures by which a substance use disorder counselor
- 1888 gathers information related to an individual's strengths, weaknesses, needs, and substance use
- 1889 disorder symptoms for the development of the treatment plan;
- 1890 (v) participating in the process of treatment planning, including recommending specific
- 1891 interventions to support existing treatment goals and objectives developed by the substance use
- 1892 disorder counselor, the mental health therapist, and the client to:
- 1893 (A) identify and rank problems needing resolution;
- 1894 (B) establish agreed upon immediate and long term goals; and
- 1895 (C) decide on a treatment process and the resources to be utilized;
- 1896 (vi) monitoring compliance with treatment plan progress;
- 1897 (vii) providing substance use disorder counseling services to alcohol and drug use
- 1898 disorder clients and significant people in the client's life as part of a comprehensive treatment
- 1899 plan, including:
- 1900 (A) leading specific task-oriented groups, didactic groups, and group discussions;
- 1901 (B) cofacilitating group therapy with a licensed mental health therapist; and
- 1902 (C) engaging in one-on-one interventions and interactions coordinated by a mental
- 1903 health therapist;
- 1904 (viii) performing case management activities that bring services, agencies, resources, or
- 1905 people together within a planned framework of action toward the achievement of established

1906 goals, including, when appropriate, liaison activities and collateral contacts;
1907 (ix) providing substance use disorder crisis intervention services;
1908 (x) providing client education to individuals and groups concerning alcohol and other
1909 substance use disorders, including identification and description of available treatment services
1910 and resources;
1911 (xi) identifying the needs of the client that cannot be met by the substance use disorder
1912 counselor or substance use disorder agency and referring the client to appropriate services and
1913 community resources;
1914 (xii) developing and providing effective reporting and recordkeeping procedures and
1915 services, which include charting the results of the assessment and treatment plan, writing
1916 reports, progress notes, discharge summaries, and other client-related data; and
1917 (xiii) consulting with other professionals in regard to client treatment and services to
1918 assure comprehensive quality care for the client.
1919 (c) "Practice as a substance use disorder counselor" does not include:
1920 (i) the diagnosing of mental illness, including substance use disorders, as defined in
1921 Section [58-60-102](#);
1922 (ii) engaging in the practice of mental health therapy as defined in Section [58-60-102](#);
1923 or
1924 (iii) the performance of a substance use disorder diagnosis, other mental illness
1925 diagnosis, or psychological testing.
1926 (11) "Program" means a substance use disorder agency that provides substance use
1927 disorder services, including recovery support services.
1928 (12) "Recovery support services" means services provided to an individual who is
1929 identified as having need of substance use disorder preventive or treatment services, either
1930 before, during, or after an episode of care that meets the level of care standards established by
1931 division rule.
1932 (13) "Substance use disorder agency" means a public or private agency, health care
1933 facility, or health care practice that:

1934 (a) provides substance use disorder services, recovery support services, primary health
1935 care services, or substance use disorder preventive services; and

1936 (b) employs qualified mental health therapists in sufficient number to:

1937 (i) evaluate the condition of clients being treated by each counselor licensed under this
1938 part and employed by the substance use disorder agency; and

1939 (ii) ensure that appropriate substance use disorder services are being given.

1940 (14) "Substance use disorder education program" means a formal program of substance
1941 use disorder education offered by an accredited institution of higher education that meets
1942 standards established by division rule.

1943 Section 41. Section **58-60-508** is amended to read:

1944 **58-60-508. Substance use disorder counselor supervisor's qualifications --**

1945 **Functions.**

1946 (1) A mental health therapist supervisor of a substance use disorder counselor shall:

1947 (a) be qualified by education or experience to treat substance use disorders;

1948 (b) be currently working in the substance use disorder treatment field;

1949 (c) review substance use disorder counselor assessment procedures and
1950 recommendations;

1951 (d) provide substance use disorder diagnosis and other mental health diagnoses in
1952 accordance with Subsection [58-60-102\(7\)](#);

1953 (e) supervise the development of a treatment plan;

1954 (f) approve the treatment plan; and

1955 (g) provide direct supervision for not more than [~~five~~] six persons, unless granted an
1956 exception in writing from the board and the division.

1957 (2) A licensed advanced substance use disorder counselor may act as the supervisor of
1958 a certified substance use disorder counselor, certified substance use disorder counselor intern,
1959 certified advanced substance use disorder counselor, or certified advanced substance use
1960 disorder counselor intern~~[, or licensed substance use disorder counselor shall]~~ if the licensed
1961 advanced substance use disorder counselor:

1962 ~~[(a) be a licensed advanced substance use disorder counselor;]~~
 1963 ~~[(b)]~~ (a) ~~[have]~~ has at least two years of experience as a licensed advanced substance
 1964 use disorder counselor;
 1965 ~~[(c)]~~ (b) ~~[be]~~ is currently working in the substance use disorder field; and
 1966 ~~[(d)]~~ (c) ~~[provide]~~ provides direct supervision for no more than ~~[three persons]~~ six
 1967 individuals, unless granted an exception in writing from the board and the division.

1968 Section 42. Section **62A-4a-902** is amended to read:

1969 **62A-4a-902. Definitions.**

1970 (1) (a) "Adoption assistance" means direct financial subsidies and support to adoptive
 1971 parents of a child with special needs or whose need or condition has created a barrier that
 1972 would prevent a successful adoption.

1973 (b) "Adoption assistance" may include state medical assistance, reimbursement of
 1974 nonrecurring adoption expenses, or monthly subsidies.

1975 (2) "Child who has a special need" means a child who cannot or should not be returned
 1976 to the home of his biological parents and who meets at least one of the following conditions:

1977 (a) the child is five years of age or older;

1978 (b) the child is under the age of 18 with a physical, emotional, or mental disability; or

1979 (c) the child is a member of a sibling group placed together for adoption.

1980 (3) "Monthly subsidy" means financial support to assist with the costs of adopting and
 1981 caring for a child who has a special need.

1982 (4) "Nonrecurring adoption expenses" means reasonably necessary adoption fees, court
 1983 costs, attorney's fees, and other expenses which are directly related to the legal adoption of a
 1984 child who has a special need.

1985 (5) "State medical assistance" means the Medicaid program and medical assistance as
 1986 those terms are defined in [Subsections 26-18-2(4) and (5)] Section 26-18-2.

1987 (6) "Supplemental adoption assistance" means financial support for extraordinary,
 1988 infrequent, or uncommon documented needs not otherwise covered by a monthly subsidy, state
 1989 medical assistance, or other public benefits for which a child who has a special need is eligible.

- 1990 Section 43. Section **63A-13-102** is amended to read:
- 1991 **63A-13-102. Definitions.**
- 1992 As used in this chapter:
- 1993 (1) "Abuse" means:
- 1994 (a) an action or practice that:
- 1995 (i) is inconsistent with sound fiscal, business, or medical practices; and
- 1996 (ii) results, or may result, in unnecessary Medicaid related costs; or
- 1997 (b) reckless or negligent upcoding.
- 1998 (2) "Claimant" means a person that:
- 1999 (a) provides a service; and
- 2000 (b) submits a claim for Medicaid reimbursement for the service.
- 2001 (3) "Department" means the Department of Health, created in Section [26-1-4](#).
- 2002 (4) "Division" means the Division of Medicaid and Health [~~Care~~] Financing, created in
- 2003 Section [26-18-2.1](#).
- 2004 (5) "Extrapolation" means a method of using a mathematical formula that takes the
- 2005 audit results from a small sample of Medicaid claims and projects those results over a much
- 2006 larger group of Medicaid claims.
- 2007 (6) "Fraud" means intentional or knowing:
- 2008 (a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a
- 2009 claim, reimbursement, or services; or
- 2010 (b) a violation of a provision of Sections [26-20-3](#) through [26-20-7](#).
- 2011 (7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's
- 2012 office.
- 2013 (8) "Health care professional" means a person licensed under:
- 2014 (a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;
- 2015 (b) Title 58, Chapter 16a, Utah Optometry Practice Act;
- 2016 (c) Title 58, Chapter 17b, Pharmacy Practice Act;
- 2017 (d) Title 58, Chapter 24b, Physical Therapy Practice Act;

- 2018 (e) Title 58, Chapter 31b, Nurse Practice Act;
- 2019 (f) Title 58, Chapter 40, Recreational Therapy Practice Act;
- 2020 (g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;
- 2021 (h) Title 58, Chapter 42a, Occupational Therapy Practice Act;
- 2022 (i) Title 58, Chapter 44a, Nurse Midwife Practice Act;
- 2023 (j) Title 58, Chapter 49, Dietitian Certification Act;
- 2024 (k) Title 58, Chapter 60, Mental Health Professional Practice Act;
- 2025 (l) Title 58, Chapter 67, Utah Medical Practice Act;
- 2026 (m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
- 2027 (n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;
- 2028 (o) Title 58, Chapter 70a, Physician Assistant Act; and
- 2029 (p) Title 58, Chapter 73, Chiropractic Physician Practice Act.
- 2030 (9) "Inspector general" means the inspector general of the office, appointed under
- 2031 Section [63A-13-201](#).
- 2032 (10) "Office" means the Office of Inspector General of Medicaid Services, created in
- 2033 Section [63A-13-201](#).
- 2034 (11) "Provider" means a person that provides:
- 2035 (a) medical assistance, including supplies or services, in exchange, directly or
- 2036 indirectly, for Medicaid funds; or
- 2037 (b) billing or recordkeeping services relating to Medicaid funds.
- 2038 (12) "Upcoding" means assigning an inaccurate billing code for a service that is
- 2039 payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking
- 2040 into account reasonable opinions derived from official published coding definitions, would
- 2041 result in a lower Medicaid payment or reimbursement.
- 2042 (13) "Waste" means overutilization of resources or inappropriate payment.
- 2043 Section 44. Section **63I-2-226** is amended to read:
- 2044 **63I-2-226. Repeal dates -- Title 26.**
- 2045 (1) Subsection [26-7-8\(3\)](#) is repealed January 1, 2027.

- 2046 [~~(2)~~] Subsection ~~26-7-9~~(5) is repealed January 1, 2019.]
- 2047 [~~(3)~~] (2) Section ~~26-8a-107~~ is repealed July 1, 2019.
- 2048 [~~(4)~~] (3) Subsection ~~26-8a-203~~(3)(a)(i) is repealed January 1, 2023.
- 2049 [~~(5)~~] (4) Subsection ~~26-18-2.3~~(5) is repealed January 1, 2020.
- 2050 [~~(6)~~] (5) Subsection ~~26-18-2.4~~(3)(e) is repealed January 1, 2023.
- 2051 [~~(7)~~] Subsection ~~26-18-408~~(6) is repealed January 2, 2019.]
- 2052 [~~(8)~~] Subsection ~~26-18-410~~(5) is repealed January 1, 2026.]
- 2053 [~~(9)~~] (6) Subsection [~~26-18-411~~(5)] ~~26-18-411~~(8), related to reporting on the health
- 2054 coverage improvement program, is repealed January 1, 2023.
- 2055 [~~(10)~~] (7) Subsection ~~26-18-604~~(2) is repealed January 1, 2020.
- 2056 [~~(11)~~] (8) Subsection ~~26-21-28~~(2)(b) is repealed January 1, 2021.
- 2057 [~~(12)~~] (9) Subsection ~~26-33a-106.1~~(2)(a) is repealed January 1, 2023.
- 2058 [~~(13)~~] (10) Subsection ~~26-33a-106.5~~(6)(c)(iii) is repealed January 1, 2020.
- 2059 [~~(14)~~] (11) Title 26, Chapter 46, Utah Health Care Workforce Financial Assistance
- 2060 Program, is repealed July 1, 2027.
- 2061 [~~(15)~~] (12) Subsection ~~26-50-202~~(7)(b) is repealed January 1, 2020.
- 2062 [~~(16)~~] (13) Subsections ~~26-54-103~~(6)(d)(ii) and (iii) are repealed January 1, 2020.
- 2063 [~~(17)~~] (14) Subsection ~~26-55-107~~(8) is repealed January 1, 2021.
- 2064 [~~(18)~~] (15) Subsection ~~26-56-103~~(9)(d) is repealed January 1, 2020.
- 2065 [~~(19)~~] (16) Title 26, Chapter 59, Telehealth Pilot Program, is repealed January 1, 2020.
- 2066 [~~(20)~~] (17) Subsection ~~26-61-202~~(4)(b) is repealed January 1, 2022.
- 2067 [~~(21)~~] (18) Subsection ~~26-61-202~~(5) is repealed January 1, 2022.
- 2068 Section 45. Section **63J-1-315** is amended to read:
- 2069 **63J-1-315. Medicaid Growth Reduction and Budget Stabilization Account --**
- 2070 **Transfers of Medicaid growth savings -- Base budget adjustments.**
- 2071 (1) As used in this section:
- 2072 (a) "Department" means the Department of Health created in Section ~~26-1-4~~.
- 2073 (b) "Division" means the Division of Medicaid and Health [~~Care~~] Financing created

2074 [~~within the department under~~] in Section 26-18-2.1.

2075 (c) "General Fund revenue surplus" means a situation where actual General Fund
2076 revenues collected in a completed fiscal year exceed the estimated revenues for the General
2077 Fund for that fiscal year that were adopted by the Executive Appropriations Committee of the
2078 Legislature.

2079 (d) "Medicaid growth savings" means the Medicaid growth target minus Medicaid
2080 program expenditures, if Medicaid program expenditures are less than the Medicaid growth
2081 target.

2082 (e) "Medicaid growth target" means Medicaid program expenditures for the previous
2083 year multiplied by 1.08.

2084 (f) "Medicaid program" is as defined in Section 26-18-2.

2085 (g) "Medicaid program expenditures" means total state revenue expended for the
2086 Medicaid program from the General Fund, including restricted accounts within the General
2087 Fund, during a fiscal year.

2088 (h) "Medicaid program expenditures for the previous year" means total state revenue
2089 expended for the Medicaid program from the General Fund, including restricted accounts
2090 within the General Fund, during the fiscal year immediately preceding a fiscal year for which
2091 Medicaid program expenditures are calculated.

2092 (i) "Operating deficit" means that, at the end of the fiscal year, the unassigned fund
2093 balance in the General Fund is less than zero.

2094 (j) "State revenue" means revenue other than federal revenue.

2095 (k) "State revenue expended for the Medicaid program" includes money transferred or
2096 appropriated to the Medicaid Growth Reduction and Budget Stabilization Account only to the
2097 extent the money is appropriated for the Medicaid program by the Legislature.

2098 (2) There is created within the General Fund a restricted account to be known as the
2099 Medicaid Growth Reduction and Budget Stabilization Account.

2100 (3) (a) (i) Except as provided in Subsection (6), if, at the end of a fiscal year, there is a
2101 General Fund revenue surplus, the Division of Finance shall transfer an amount equal to

2102 Medicaid growth savings from the General Fund to the Medicaid Growth Reduction and
2103 Budget Stabilization Account.

2104 (ii) If the amount transferred is reduced to prevent an operating deficit, as provided in
2105 Subsection (6), the Legislature shall include, to the extent revenue is available, an amount
2106 equal to the reduction as an appropriation from the General Fund to the account in the base
2107 budget for the second fiscal year following the fiscal year for which the reduction was made.

2108 (b) If, at the end of a fiscal year, there is not a General Fund revenue surplus, the
2109 Legislature shall include, to the extent revenue is available, an amount equal to Medicaid
2110 growth savings as an appropriation from the General Fund to the account in the base budget for
2111 the second fiscal year following the fiscal year for which the reduction was made.

2112 (c) Subsections (3)(a) and (3)(b) apply only to the fiscal year in which the department
2113 implements the proposal developed under Section 26-18-405 to reduce the long-term growth in
2114 state expenditures for the Medicaid program, and to each fiscal year after that year.

2115 (4) The Division of Finance shall calculate the amount to be transferred under
2116 Subsection (3):

2117 (a) before transferring revenue from the General Fund revenue surplus to:

2118 (i) the General Fund Budget Reserve Account under Section 63J-1-312;

2119 (ii) the Wildland Fire Suppression Fund created in Section 65A-8-204, as described in
2120 Section 63J-1-314; and

2121 (iii) the State Disaster Recovery Restricted Account under Section 63J-1-314;

2122 (b) before earmarking revenue from the General Fund revenue surplus to the Industrial
2123 Assistance Account under Section 63N-3-106; and

2124 (c) before making any other year-end contingency appropriations, year-end set-asides,
2125 or other year-end transfers required by law.

2126 (5) (a) If, at the close of any fiscal year, there appears to be insufficient money to pay
2127 additional debt service for any bonded debt authorized by the Legislature, the Division of
2128 Finance may hold back from any General Fund revenue surplus money sufficient to pay the
2129 additional debt service requirements resulting from issuance of bonded debt that was

2130 authorized by the Legislature.

2131 (b) The Division of Finance may not spend the hold back amount for debt service
2132 under Subsection (5)(a) unless and until it is appropriated by the Legislature.

2133 (c) If, after calculating the amount for transfer under Subsection (3), the remaining
2134 General Fund revenue surplus is insufficient to cover the hold back for debt service required by
2135 Subsection (5)(a), the Division of Finance shall reduce the transfer to the Medicaid Growth
2136 Reduction and Budget Stabilization Account by the amount necessary to cover the debt service
2137 hold back.

2138 (d) Notwithstanding Subsections (3) and (4), the Division of Finance shall hold back
2139 the General Fund balance for debt service authorized by this Subsection (5) before making any
2140 transfers to the Medicaid Growth Reduction and Budget Stabilization Account or any other
2141 designation or allocation of General Fund revenue surplus.

2142 (6) Notwithstanding Subsections (3) and (4), if, at the end of a fiscal year, the Division
2143 of Finance determines that an operating deficit exists and that holding back earmarks to the
2144 Industrial Assistance Account under Section [63N-3-106](#), transfers to the Wildland Fire
2145 Suppression Fund and State Disaster Recovery Restricted Account under Section [63J-1-314](#),
2146 transfers to the General Fund Budget Reserve Account under Section [63J-1-312](#), or earmarks
2147 and transfers to more than one of those accounts, in that order, does not eliminate the operating
2148 deficit, the Division of Finance may reduce the transfer to the Medicaid Growth Reduction and
2149 Budget Stabilization Account by the amount necessary to eliminate the operating deficit.

2150 (7) The Legislature may appropriate money from the Medicaid Growth Reduction and
2151 Budget Stabilization Account only:

2152 (a) if Medicaid program expenditures for the fiscal year for which the appropriation is
2153 made are estimated to be 108% or more of Medicaid program expenditures for the previous
2154 year; and

2155 (b) for the Medicaid program.

2156 (8) The Division of Finance shall deposit interest or other earnings derived from
2157 investment of Medicaid Growth Reduction and Budget Stabilization Account money into the

2158 General Fund.

2159 Section 46. **Repealer.**

2160 This bill repeals:

2161 Section **26-18-3.2, Release of financial information.**

2162 Section **26-18-10, Utah Medical Assistance Program -- Policies and standards.**

2163 Section **26-18-14, Strategic plan for health system reform -- Medicaid program.**

2164 Section **26-18-406, Medicaid waiver for community service pilot program.**

2165 Section **26-18-407, Medicaid waiver for autism spectrum disorder.**