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HEALTH CARE AMENDMENTS

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

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

Highlighted Provisions:

This bill:

- creates and amends definitions;
- renames the Division of Health Care Financing to the Division of Medicaid and Health Financing;
- requires the Department of Health to coordinate with the Office of the Inspector General for Medicaid Services;
- changes provisions related to enrollment and renewal processes for the Medicaid program and the Children's Health Insurance Program;
- deletes provisions related to the Primary Care Network demonstration waiver;
- amends provisions related to the spouse of an individual residing in a nursing facility and receiving Medicaid services;
- modifies contracting provisions for the Department of Health;
- eliminates certain reporting requirements;
- amends benefits benchmark requirements for the Utah Children's Health Insurance Program;
- removes certain repealers;

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- repeals provisions from the Medical Assistance Act related to:
  - the release of financial information;
  - a strategic plan for health system reform; and
  - certain waiver provisions; and
- makes clarifying and other technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-18-2, as last amended by Laws of Utah 2000, Chapter 1
26-18-2.1, as enacted by Laws of Utah 1988, Chapter 21
26-18-2.3, as last amended by Laws of Utah 2012, Chapter 242
26-18-2.5, as last amended by Laws of Utah 2012, Chapter 279
26-18-3.5, as last amended by Laws of Utah 2006, Chapter 148
26-18-3.6, as last amended by Laws of Utah 2015, Chapter 258
26-18-5, as last amended by Laws of Utah 2011, Chapter 297
26-18-11, as last amended by Laws of Utah 2011, Chapter 297
26-18-18, as last amended by Laws of Utah 2018, Chapter 468
26-18-21, as last amended by Laws of Utah 2018, Chapter 467
26-18-404, as enacted by Laws of Utah 2007, Chapter 190
26-18-408, as last amended by Laws of Utah 2017, Chapter 22
26-18-410, as last amended by Laws of Utah 2018, Chapter 193
26-18-411, as last amended by Laws of Utah 2018, Chapter 384
26-18-413, as last amended by Laws of Utah 2018, Chapter 78
26-18-415, as enacted by Laws of Utah 2018, Chapter 468
26-18-416, as enacted by Laws of Utah 2018, Chapter 384
26-18-417, as enacted by Laws of Utah 2018, Chapter 180
26-18-418, as enacted by Laws of Utah 2018, Chapter 408
26-18-503, as last amended by Laws of Utah 2017, Chapter 443

26-36b-202, as last amended by Laws of Utah 2018, Chapters 384 and 468
26-36c-202, as enacted by Laws of Utah 2018, Chapter 468
26-40-102, as last amended by Laws of Utah 2000, Chapters 1 and 351
26-40-103, as last amended by Laws of Utah 2017, Chapter 74
26-40-105, as last amended by Laws of Utah 2011, Chapter 344
26-40-106, as last amended by Laws of Utah 2015, Chapter 107
26-40-110, as last amended by Laws of Utah 2015, Chapter 107
26-40-115, as last amended by Laws of Utah 2018, Chapter 319
26-40-116, as enacted by Laws of Utah 2013, Chapter 103
62A-4a-902, as last amended by Laws of Utah 2006, Chapter 116
63A-13-102, as last amended by Laws of Utah 2015, Chapter 135
63I-2-226, as last amended by Laws of Utah 2018, Chapters 38 and 281
63J-1-315, as last amended by Laws of Utah 2016, Chapter 183

REPEALS:

26-18-3.2, as enacted by Laws of Utah 2010, Chapter 347
26-18-10, as last amended by Laws of Utah 2017, Chapter 74
26-18-14, as last amended by Laws of Utah 2015, Chapter 283
26-18-406, as last amended by Laws of Utah 2013, Chapter 167
26-18-407, as last amended by Laws of Utah 2017, Chapter 22

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

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

26-18-2. Definitions.

As used in this chapter:

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

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

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

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

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

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

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

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

(b) "Passenger vehicle" does not include:

(i) a commercial vehicle, as defined in Section 41-1a-102;

(ii) an off-highway vehicle, as defined in Section 41-1a-102; or

(iii) a motor home, as defined in Section 13-14-102.

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

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

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

26-18-2.1. Division -- Creation.

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

Section 3. Section **26-18-2.3** is amended to read:

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

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

(a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;

(b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and

(c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

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

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) consistent with Sections 26-18-2.4 and 58-17b-606, a Medicaid drug program;

(g) coordination of benefits; and

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

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

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

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

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

(a) measures taken under this section to increase:

(i) efficiencies within the program; and

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

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

Section 4. Section **26-18-2.5** is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The department may disclose a financial record obtained from a financial institution under this section only for the purpose of, and to the extent necessary in, verifying eligibility as provided in this section and Section 26-40-105.

Section 5. Section **26-18-3.5** is amended to read:

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

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

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

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

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

[~~(3)~~] (2) Beginning May 1, 2006, within appropriations by the Legislature and as a

means to increase health care coverage among the uninsured, the department shall take steps to promote increased participation in employer sponsored health insurance, including:

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

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

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

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

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

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

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

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

Section 6. Section **26-18-3.6** is amended to read:

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

(1) As used in this section:

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

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

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

(c) "Community spouse resource allowance" is [~~an amount by which the greatest of the following exceeds the amount of the resources otherwise available to the community spouse:~~] the amount of combined resources that are protected for a community spouse living in the

community, which the division shall establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the United States Department of Health and Human Services.

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

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

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

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

(d) "Excess shelter allowance" for a community spouse means the amount by which the sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case of condominium or cooperative, required maintenance charge, for the community spouse's principal residence and the spouse's actual expenses for electricity, natural gas, and water utilities or, at the discretion of the department, the federal standard utility allowance under SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection (9).

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

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

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

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

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

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

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

(a) the total value of the resources to the extent either the institutionalized spouse or

the community spouse has an ownership interest; and

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

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

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

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

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

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

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

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

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

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

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

(8) During the continuous period in which an institutionalized spouse is in an

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the community spouse monthly income allowance;

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

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

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

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

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

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

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

Section 7. Section **26-18-5** is amended to read:

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

(1) The department may contract with other public or private agencies to purchase or

provide medical services in connection with the programs of the division. Where these programs are used by other state agencies, contracts shall provide that other state agencies transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.

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

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

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

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

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

Section 8. Section **26-18-11** is amended to read:

26-18-11. Rural hospitals.

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

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

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

26-18-18. Optional Medicaid expansion.

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

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

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

[~~(2)~~] (1) The department and the governor may not expand the state's Medicaid

program under PPACA unless:

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

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

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

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

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

Section 10. Section **26-18-21** is amended to read:

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

(1) As used in this section:

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

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

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

(ii) "Intergovernmental transfer" does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) other information the department gathers about the intergovernmental transfer under Subsection (2)(a).

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

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

(b) (i) If the nursing care facility expects to receive less than $1,000,000 in federal funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment

Limit program, excluding seed funding and administrative fees paid by the non-state government entity, the department shall enter into a Nursing Care Facility Non-State Government-Owned Upper Payment Limit program contract with the non-state government entity operator of the nursing care facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 11. Section **26-18-404** is amended to read:

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

If the department receives approval from [~~the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services~~] CMS to replace the Medicaid program's current FlexCare program with a new program to provide long-term care services in home and community-based settings rather than institutions, the department shall assist in the payment of room and board costs for any person in the new program without sufficient income to fully pay those costs.

Section 12. Section **26-18-408** is amended to read:

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

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

(b) For purposes of this section:

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

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

(iii) "Nonemergent care":

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

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

(iv) "Professional compensation" means payment made for services rendered to a

Medicaid recipient by an individual licensed to provide health care services.

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

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

(i) audit emergency department services provided to a recipient enrolled in the accountable care plan to determine if nonemergent care was provided to the recipient; and

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

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

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

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

(3) An accountable care organization shall:

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

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

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

(4) The department shall:

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

(i) appropriate emergency department services to recipients enrolled in the accountable

care plan;

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

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

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

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

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

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

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

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

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

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

(i) creating increased access to primary care services;

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

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

(iv) case management programs that can:

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

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

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

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

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

Section 13. Section **26-18-410** is amended to read:

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

(1) As used in this section:

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

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

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

(ii) is likely to:

(A) last at least 12 months; or

(B) result in death.

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

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

(i) is less than 19 years old;

(ii) is diagnosed with a complex medical condition;

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

(iv) meets the additional eligibility criteria.

(2) The department shall apply for a Medicaid home and community-based waiver with

[~~the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services~~] CMS to implement, within the state Medicaid program, the program described in Subsection (3).

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

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

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

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

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

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

(4) The department shall:

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

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

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

(b) convene a public process to determine:

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

(ii) additional eligibility criteria for a qualified child;

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

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

(e) establish, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, additional eligibility criteria based on the factors described in Subsections (4)(a)(i) and (ii).

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

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

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

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

Section 14. Section **26-18-411** is amended to read:

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

(1) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to allow temporary residential treatment for substance abuse, for the traditional Medicaid population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that provides rehabilitation services that are medically necessary and in accordance with an

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

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

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

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

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

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

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

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

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

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

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

(i) at the time of enrollment, the individual's annual income is below the income

eligibility ceiling established by the state under Subsection (1)[~~(g)~~](f); and

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

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

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

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

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

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

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

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

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

(a) the number of individuals who enrolled in Medicaid under Subsection (6);

(b) the state cost of providing Medicaid to individuals enrolled under Subsection (6); and

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

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

Medicaid before incarceration.

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

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

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

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

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

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

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

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

Section 15. Section **26-18-413** is amended to read:

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

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

(b) Before June 30, 2018, the department shall submit to [~~the Centers for Medicare and Medicaid Services~~] CMS a request for waivers, or an amendment of existing waivers, from

federal law necessary for the state to provide dental services, in accordance with Subsections (2)(b) through (g), to an individual described in Subsection (2)(b).

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

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

(i) qualifies for the health coverage improvement program described in Section 26-18-411; and

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

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

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

(i) by contracting with an entity that:

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

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

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

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

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

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

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

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

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

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

(ii) after July 1, 2018, through the method of reimbursement used by the division for Medicaid dental benefits.

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

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

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

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

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

Section 16. Section **26-18-415** is amended to read:

26-18-415. Medicaid waiver expansion.

(1) As used in this section:

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

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

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

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

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

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

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

(b) The Medicaid waiver expansion shall:

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

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

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

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

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

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

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

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

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

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

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

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

(4) Medicaid accountable care organizations and counties that elect to integrate care

under Subsection (2)(b)(iv) shall collaborate on enrollment, engagement of patients, and coordination of services.

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

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

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

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

(b) costs to the state for the Medicaid waiver program;

(c) estimated costs for the current and following state fiscal year; and

(d) recommendations to control costs of the Medicaid waiver expansion.

Section 17. Section **26-18-416** is amended to read:

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

(1) As used in this section:

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

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

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

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

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

(i) established by the Legislature in an appropriations act adopted pursuant to Title 63J,

Chapter 1, Budgetary Procedures Act; and

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

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

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

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

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

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

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

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

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

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

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

(b) diagnostic testing and procedures;

(c) medical specialty care;

(d) inpatient hospital services;

(e) outpatient hospital services;

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

(g) for an individual who qualifies for the health coverage improvement program, as approved by CMS, temporary residential treatment for substance abuse in a short term,

non-institutional, 24-hour facility, without a bed capacity limit, that provides rehabilitation services that are medically necessary and in accordance with an individualized treatment plan.

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

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

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

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

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

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

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

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

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

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

(c) The department may only use appropriations from the Medicaid Expansion Fund created in Section 26-36b-208 to fund the state portion of the enhancement waiver program.

(d) The money deposited into the Medicaid Expansion Fund under Subsections [~~26-36b-208(g) and (h)~~] 26-36b-208(2)(i) and (j) may only be used to pay the cost of enrolling individuals who qualify for the enhancement waiver program under Subsections (6)(a)(iii) and (iv).

(7) The department may request a modification of the income eligibility ceiling and the eligibility criteria under Subsection (6) from CMS each fiscal year based on enrollment in the

enhancement waiver program, projected enrollment in the enhancement waiver program, costs to the state, and the state budget.

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

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

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

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

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

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

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

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

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

(1) As used in this section:

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

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

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

(ii) "Family planning services" do not include an abortion, as that term is defined in

Section 76-7-301.

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

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

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

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

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

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

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

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

(b) the cost of the program; and

(c) the effectiveness of the program, including:

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

(ii) any reduction in the number of abortions;

(iii) any reduction in the number of unintended pregnancies;

(iv) any reduction in the number of individuals requiring services from the Women, Infants, and Children Program established in 42 U.S.C. Sec. 1786; and

(v) any other costs and benefits as a result of the program.

Section 19. Section **26-18-418** is amended to read:

26-18-418. Medicaid waiver for mental health crisis lines and mobile crisis outreach teams.

(1) As used in this section:

(a) "Local mental health crisis line" means the same as that term is defined in Section 63C-18-102.

(b) "Mental health crisis" means:

(i) a mental health condition that manifests itself in an individual by symptoms of

sufficient severity that a prudent layperson who possesses an average knowledge of mental health issues could reasonably expect the absence of immediate attention or intervention to result in:

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

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

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

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

(ii) "Mental health crisis services" includes:

(A) local mental health crisis lines; and

(B) the statewide mental health crisis line.

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

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

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

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

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

Section 20. Section **26-18-503** is amended to read:

26-18-503. Authorization to renew, transfer, or increase Medicaid certified programs -- Reimbursement methodology.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) if a third party is found, by final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at

the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

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

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

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

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

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

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

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

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

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

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

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

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

(i) whether bed capacity provided by certified programs within the county or group of

counties impacted by the requested additional Medicaid certification is insufficient, based on the information submitted to the director under Subsection (5)(b);

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

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

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

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

(B) information obtained under Subsection (9).

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

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

(i) actual occupancy; or

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

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

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

(7) (a) Notwithstanding Subsection 26-18-504[~~(4)~~](3), if a nursing care facility does not seek Medicaid certification for a bed under Subsections (1) through (6), the department shall grant Medicaid certification for additional beds in an existing Medicaid certified nursing care facility that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility if:

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

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

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

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

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

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

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

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

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

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

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

Section 21. Section **26-36b-202** is amended to read:

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

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

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

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

(b) audit records of a facility that:

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

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

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

(3) The department shall:

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

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

Section 22. Section **26-36c-202** is amended to read:

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

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

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

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

(b) audit records of a facility that:

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

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

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

(3) The department shall:

(a) administer the assessment in this part separately from the assessments in Chapter

[~~36a~~] 36d, Hospital Provider Assessment Act, and Chapter 36b, Inpatient Hospital Assessment Act; and

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

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

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

Section 23. Section **26-40-102** is amended to read:

26-40-102. Definitions.

As used in this chapter:

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

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

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

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

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

Section 24. Section **26-40-103** is amended to read:

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

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

(a) this chapter; and

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

(2) The department shall:

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

(b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative

Rulemaking Act regarding:

(i) eligibility requirements consistent with Section 26-18-3;

(ii) program benefits;

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

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

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

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

(v) the administration of the program; and

(vi) a requirement that:

(A) [~~enrollees~~] members in the program shall participate in the electronic exchange of clinical health records established in accordance with Section 26-1-37 unless the [~~enrollee~~] member opts out of participation;

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

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

Section 25. Section **26-40-105** is amended to read:

26-40-105. Eligibility.

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

(a) is a bona fide Utah resident;

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

(c) is under 19 years of age;

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

(e) is ineligible for Medicaid benefits;

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

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

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

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

(b) If the department cannot reach a decision because the applicant fails to take a required action, or because there is an administrative or other emergency beyond the department's control, the department shall:

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

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

(4) The department may not close enrollment in the program for a child who is eligible to enroll in the program under the provisions of Subsection (1).

(5) [~~(a)~~] The program shall:

[~~(i)~~] (a) apply for grants to make technology system improvements necessary to implement a simplified enrollment and renewal process in accordance with [~~this~~] Subsection (5)(b); and

[~~(ii)~~] (b) if funding is available, implement [~~the~~] a simplified enrollment and renewal process [~~in accordance with this Subsection (5)~~].

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

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

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

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

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

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

[~~(C) obtains from the Utah State Tax Commission, the adjusted gross income of the applicant; and~~]

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

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

26-40-106. Program benefits.

(1) Except as provided in Subsection [~~(4)~~] (3), medical and dental program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, [~~to be actuarially equivalent~~] as follows:

(a) medical program benefits, including behavioral health care benefits, shall be benchmarked on July 1, 2019, and on July 1 every third year thereafter, to:

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

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

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

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

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

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

(b) dental program benefits shall be benchmarked on July 1, 2019, and on July 1 every third year thereafter in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, to be [~~equivalent~~] substantially equal to a dental benefit plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the state, except that the utilization review mechanism for orthodontia shall be based on medical necessity. [~~Dental program benefits shall be adjusted on July 1, 2012, and on July 1 every three years thereafter to meet the benefit level required by this Subsection (3).~~]

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

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

Section 27. Section **26-40-110** is amended to read:

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

(1) Program benefits provided to [~~enrollees~~] a member under the program, as described in Section 26-40-106, shall be delivered by a managed care organization if the department

determines that adequate services are available where the [~~enrollee~~] member lives or resides.

(2) The department may contract with a managed care organization to provide program benefits. The department shall [~~use the following criteria to~~] evaluate a potential contract with a managed care organization based on:

(a) the managed care organization's:

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

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

(iii) efficiency of claim paying procedures;

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

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) estimated total charges for administering the pool;

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

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

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

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

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

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

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

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

Section 28. Section **26-40-115** is amended to read:

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

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

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

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

(i) has a deductible that is:

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

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

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

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

(2) The department shall:

(a) on or before July 1, 2016:

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

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

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

Section 29. Section **26-40-116** is amended to read:

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

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

Section 30. Section **62A-4a-902** is amended to read:

62A-4a-902. Definitions.

(1) (a) "Adoption assistance" means direct financial subsidies and support to adoptive parents of a child with special needs or whose need or condition has created a barrier that would prevent a successful adoption.

(b) "Adoption assistance" may include state medical assistance, reimbursement of nonrecurring adoption expenses, or monthly subsidies.

(2) "Child who has a special need" means a child who cannot or should not be returned to the home of his biological parents and who meets at least one of the following conditions:

(a) the child is five years of age or older;

(b) the child is under the age of 18 with a physical, emotional, or mental disability; or

(c) the child is a member of a sibling group placed together for adoption.

(3) "Monthly subsidy" means financial support to assist with the costs of adopting and caring for a child who has a special need.

(4) "Nonrecurring adoption expenses" means reasonably necessary adoption fees, court costs, attorney's fees, and other expenses which are directly related to the legal adoption of a child who has a special need.

(5) "State medical assistance" means the Medicaid program and medical assistance as those terms are defined in [~~Subsections 26-18-2(4) and (5)~~] Section 26-18-2.

(6) "Supplemental adoption assistance" means financial support for extraordinary, infrequent, or uncommon documented needs not otherwise covered by a monthly subsidy, state medical assistance, or other public benefits for which a child who has a special need is eligible.

Section 31. Section **63A-13-102** is amended to read:

63A-13-102. Definitions.

As used in this chapter:

(1) "Abuse" means:

(a) an action or practice that:

(i) is inconsistent with sound fiscal, business, or medical practices; and

(ii) results, or may result, in unnecessary Medicaid related costs; or

(b) reckless or negligent upcoding.

(2) "Claimant" means a person that:

(a) provides a service; and

(b) submits a claim for Medicaid reimbursement for the service.

(3) "Department" means the Department of Health, created in Section 26-1-4.

(4) "Division" means the Division of Medicaid and Health [~~Care~~] Financing, created in Section 26-18-2.1.

(5) "Extrapolation" means a method of using a mathematical formula that takes the audit results from a small sample of Medicaid claims and projects those results over a much larger group of Medicaid claims.

(6) "Fraud" means intentional or knowing:

(a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a claim, reimbursement, or services; or

(b) a violation of a provision of Sections 26-20-3 through 26-20-7.

(7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's office.

(8) "Health care professional" means a person licensed under:

(a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;

(b) Title 58, Chapter 16a, Utah Optometry Practice Act;

(c) Title 58, Chapter 17b, Pharmacy Practice Act;

(d) Title 58, Chapter 24b, Physical Therapy Practice Act;

(e) Title 58, Chapter 31b, Nurse Practice Act;

(f) Title 58, Chapter 40, Recreational Therapy Practice Act;

(g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;

(h) Title 58, Chapter 42a, Occupational Therapy Practice Act;

(i) Title 58, Chapter 44a, Nurse Midwife Practice Act;

(j) Title 58, Chapter 49, Dietitian Certification Act;

(k) Title 58, Chapter 60, Mental Health Professional Practice Act;

(l) Title 58, Chapter 67, Utah Medical Practice Act;

(m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;

(n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;

(o) Title 58, Chapter 70a, Physician Assistant Act; and

(p) Title 58, Chapter 73, Chiropractic Physician Practice Act.

(9) "Inspector general" means the inspector general of the office, appointed under Section 63A-13-201.

(10) "Office" means the Office of Inspector General of Medicaid Services, created in Section 63A-13-201.

(11) "Provider" means a person that provides:

(a) medical assistance, including supplies or services, in exchange, directly or indirectly, for Medicaid funds; or

(b) billing or recordkeeping services relating to Medicaid funds.

(12) "Upcoding" means assigning an inaccurate billing code for a service that is payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.

(13) "Waste" means overutilization of resources or inappropriate payment.

Section 32. Section **63I-2-226** is amended to read:

63I-2-226. Repeal dates -- Title 26.

(1) Subsection 26-7-8(3) is repealed January 1, 2027.

[~~(2) Subsection 26-7-9(5) is repealed January 1, 2019.~~]

[~~(3)~~] (2) Section 26-8a-107 is repealed July 1, 2019.

[~~(4)~~] (3) Subsection 26-8a-203(3)(a)(i) is repealed January 1, 2023.

[~~(5)~~] (4) Subsection 26-18-2.3(5) is repealed January 1, 2020.

[~~(6)~~] (5) Subsection 26-18-2.4(3)(e) is repealed January 1, 2023.

[~~(7) Subsection 26-18-408(6) is repealed January 2, 2019.~~]

[~~(8) Subsection 26-18-410(5) is repealed January 1, 2026.~~]

[~~(9)~~] (6) Subsection [~~26-18-411(5)~~] 26-18-411(8), related to reporting on the health coverage improvement program, is repealed January 1, 2023.

[~~(10)~~] (7) Subsection 26-18-604(2) is repealed January 1, 2020.

[~~(11)~~] (8) Subsection 26-21-28(2)(b) is repealed January 1, 2021.

[~~(12)~~] (9) Subsection 26-33a-106.1(2)(a) is repealed January 1, 2023.

[~~(13)~~] (10) Subsection 26-33a-106.5(6)(c)(iii) is repealed January 1, 2020.

[~~(14)~~] (11) Title 26, Chapter 46, Utah Health Care Workforce Financial Assistance Program, is repealed July 1, 2027.

[~~(15)~~] (12) Subsection 26-50-202(7)(b) is repealed January 1, 2020.

[~~(16)~~] (13) Subsections 26-54-103(6)(d)(ii) and (iii) are repealed January 1, 2020.

[~~(17)~~] (14) Subsection 26-55-107(8) is repealed January 1, 2021.

[~~(18)~~] (15) Subsection 26-56-103(9)(d) is repealed January 1, 2020.

[~~(19)~~] (16) Title 26, Chapter 59, Telehealth Pilot Program, is repealed January 1, 2020.

[~~(20)~~] (17) Subsection 26-61-202(4)(b) is repealed January 1, 2022.

[~~(21)~~] (18) Subsection 26-61-202(5) is repealed January 1, 2022.

Section 33. Section **63J-1-315** is amended to read:

63J-1-315. Medicaid Growth Reduction and Budget Stabilization Account -- Transfers of Medicaid growth savings -- Base budget adjustments.

(1) As used in this section:

(a) "Department" means the Department of Health created in Section 26-1-4.

(b) "Division" means the Division of Medicaid and Health [~~Care~~] Financing created [~~within the department under~~] in Section 26-18-2.1.

(c) "General Fund revenue surplus" means a situation where actual General Fund revenues collected in a completed fiscal year exceed the estimated revenues for the General Fund for that fiscal year that were adopted by the Executive Appropriations Committee of the Legislature.

(d) "Medicaid growth savings" means the Medicaid growth target minus Medicaid program expenditures, if Medicaid program expenditures are less than the Medicaid growth target.

(e) "Medicaid growth target" means Medicaid program expenditures for the previous year multiplied by 1.08.

(f) "Medicaid program" is as defined in Section 26-18-2.

(g) "Medicaid program expenditures" means total state revenue expended for the Medicaid program from the General Fund, including restricted accounts within the General

Fund, during a fiscal year.

(h) "Medicaid program expenditures for the previous year" means total state revenue expended for the Medicaid program from the General Fund, including restricted accounts within the General Fund, during the fiscal year immediately preceding a fiscal year for which Medicaid program expenditures are calculated.

(i) "Operating deficit" means that, at the end of the fiscal year, the unassigned fund balance in the General Fund is less than zero.

(j) "State revenue" means revenue other than federal revenue.

(k) "State revenue expended for the Medicaid program" includes money transferred or appropriated to the Medicaid Growth Reduction and Budget Stabilization Account only to the extent the money is appropriated for the Medicaid program by the Legislature.

(2) There is created within the General Fund a restricted account to be known as the Medicaid Growth Reduction and Budget Stabilization Account.

(3) (a) (i) Except as provided in Subsection (6), if, at the end of a fiscal year, there is a General Fund revenue surplus, the Division of Finance shall transfer an amount equal to Medicaid growth savings from the General Fund to the Medicaid Growth Reduction and Budget Stabilization Account.

(ii) If the amount transferred is reduced to prevent an operating deficit, as provided in Subsection (6), the Legislature shall include, to the extent revenue is available, an amount equal to the reduction as an appropriation from the General Fund to the account in the base budget for the second fiscal year following the fiscal year for which the reduction was made.

(b) If, at the end of a fiscal year, there is not a General Fund revenue surplus, the Legislature shall include, to the extent revenue is available, an amount equal to Medicaid growth savings as an appropriation from the General Fund to the account in the base budget for the second fiscal year following the fiscal year for which the reduction was made.

(c) Subsections (3)(a) and (3)(b) apply only to the fiscal year in which the department implements the proposal developed under Section 26-18-405 to reduce the long-term growth in state expenditures for the Medicaid program, and to each fiscal year after that year.

(4) The Division of Finance shall calculate the amount to be transferred under Subsection (3):

(a) before transferring revenue from the General Fund revenue surplus to:

(i) the General Fund Budget Reserve Account under Section 63J-1-312;

(ii) the Wildland Fire Suppression Fund created in Section 65A-8-204, as described in Section 63J-1-314; and

(iii) the State Disaster Recovery Restricted Account under Section 63J-1-314;

(b) before earmarking revenue from the General Fund revenue surplus to the Industrial Assistance Account under Section 63N-3-106; and

(c) before making any other year-end contingency appropriations, year-end set-asides, or other year-end transfers required by law.

(5) (a) If, at the close of any fiscal year, there appears to be insufficient money to pay additional debt service for any bonded debt authorized by the Legislature, the Division of Finance may hold back from any General Fund revenue surplus money sufficient to pay the additional debt service requirements resulting from issuance of bonded debt that was authorized by the Legislature.

(b) The Division of Finance may not spend the hold back amount for debt service under Subsection (5)(a) unless and until it is appropriated by the Legislature.

(c) If, after calculating the amount for transfer under Subsection (3), the remaining General Fund revenue surplus is insufficient to cover the hold back for debt service required by Subsection (5)(a), the Division of Finance shall reduce the transfer to the Medicaid Growth Reduction and Budget Stabilization Account by the amount necessary to cover the debt service hold back.

(d) Notwithstanding Subsections (3) and (4), the Division of Finance shall hold back the General Fund balance for debt service authorized by this Subsection (5) before making any transfers to the Medicaid Growth Reduction and Budget Stabilization Account or any other designation or allocation of General Fund revenue surplus.

(6) Notwithstanding Subsections (3) and (4), if, at the end of a fiscal year, the Division of Finance determines that an operating deficit exists and that holding back earmarks to the Industrial Assistance Account under Section 63N-3-106, transfers to the Wildland Fire Suppression Fund and State Disaster Recovery Restricted Account under Section 63J-1-314, transfers to the General Fund Budget Reserve Account under Section 63J-1-312, or earmarks and transfers to more than one of those accounts, in that order, does not eliminate the operating deficit, the Division of Finance may reduce the transfer to the Medicaid Growth Reduction and

Budget Stabilization Account by the amount necessary to eliminate the operating deficit.

(7) The Legislature may appropriate money from the Medicaid Growth Reduction and Budget Stabilization Account only:

(a) if Medicaid program expenditures for the fiscal year for which the appropriation is made are estimated to be 108% or more of Medicaid program expenditures for the previous year; and

(b) for the Medicaid program.

(8) The Division of Finance shall deposit interest or other earnings derived from investment of Medicaid Growth Reduction and Budget Stabilization Account money into the General Fund.

Section 34. **Repealer.**

This bill repeals:

Section **26-18-3.2, Release of financial information.**

Section **26-18-10, Utah Medical Assistance Program -- Policies and standards.**

Section **26-18-14, Strategic plan for health system reform -- Medicaid program.**

Section **26-18-406, Medicaid waiver for community service pilot program.**

Section **26-18-407, Medicaid waiver for autism spectrum disorder.**