

1 **HEALTH AND HUMAN SERVICES AMENDMENTS**

2 2020 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: Allen M. Christensen

7 **LONG TITLE**

8 **General Description:**

9 This bill amends provisions related to health and human services.

10 **Highlighted Provisions:**

11 This bill:

- 12 ▶ amends provisions relating to Medicaid;
- 13 ▶ amends provisions for the financing of the Utah Premium Partnership for Health
- 14 Insurance program;
- 15 ▶ updates the Drug Utilization Review reporting requirements;
- 16 ▶ updates certain background check requirements for individuals who have direct
- 17 access to children or vulnerable adults;
- 18 ▶ allows for transportation during a temporary commitment to occur via a
- 19 nonemergency secured behavioral transport in certain circumstances; and
- 20 ▶ makes technical changes.

21 **Money Appropriated in this Bill:**

22 None

23 **Other Special Clauses:**

24 None

25 **Utah Code Sections Affected:**

26 AMENDS:

27 **26-18-2.3**, as last amended by Laws of Utah 2019, Chapter 393



- 28 **26-18-2.6**, as last amended by Laws of Utah 2017, Chapter 22
- 29 **26-18-3.1**, as last amended by Laws of Utah 2019, Chapter 1
- 30 **26-18-3.8**, as last amended by Laws of Utah 2013, Chapter 137
- 31 **26-18-3.9**, as last amended by Laws of Utah 2019, Chapter 1
- 32 **26-18-5**, as last amended by Laws of Utah 2019, Chapter 393
- 33 **26-18-8**, as last amended by Laws of Utah 2003, Chapter 90
- 34 **26-18-103**, as last amended by Laws of Utah 2013, Chapter 167
- 35 **26-18-408**, as last amended by Laws of Utah 2019, Chapter 393
- 36 **26-18-411**, as last amended by Laws of Utah 2019, Chapter 393
- 37 **26-18-413**, as last amended by Laws of Utah 2019, Chapters 60 and 393
- 38 **26-36b-204**, as last amended by Laws of Utah 2018, Chapters 384 and 468
- 39 **26-36b-205**, as last amended by Laws of Utah 2018, Chapters 384 and 468
- 40 **26-36c-204**, as last amended by Laws of Utah 2019, Chapter 1
- 41 **26-40-106**, as last amended by Laws of Utah 2019, Chapter 393
- 42 **62A-2-120**, as last amended by Laws of Utah 2019, Chapter 335
- 43 **62A-15-629**, as last amended by Laws of Utah 2018, Chapter 322

44 REPEALS:

- 45 **26-18-404**, as last amended by Laws of Utah 2019, Chapter 393
- 46 **26-40-116**, as last amended by Laws of Utah 2019, Chapter 393



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

49 Section 1. Section **26-18-2.3** is amended to read:

50 **26-18-2.3. Division responsibilities -- Emphasis -- Periodic assessment.**

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

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

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

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

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

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

65 (b) preadmission certification of nonemergency admissions;

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

67 (d) second surgical opinions;

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

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

70 (g) coordination of benefits; and

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

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

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

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

83 Section 2. Section 26-18-2.6 is amended to read:

84 **26-18-2.6. Dental benefits.**

85 (1) (a) Except as provided in Subsection (8), the division [~~shall~~] may establish a
86 competitive bid process to bid out Medicaid dental benefits under this chapter.

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

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

- 90 (a) ability to manage dental expenses;
- 91 (b) proven ability to handle dental insurance;
- 92 (c) efficiency of claim paying procedures;
- 93 (d) provider contracting, discounts, and adequacy of network; and
- 94 (e) other criteria established by the department.
- 95 (3) The division ~~[shall]~~ may request bids for the program's benefits[:] at least once
- 96 every five years.
- 97 ~~[(a) in 2011; and]~~
- 98 ~~[(b) at least once every five years thereafter.]~~
- 99 (4) The division's contract with dental plans for the program's benefits shall include
- 100 risk sharing provisions in which the dental plan must accept 100% of the risk for any difference
- 101 between the division's premium payments per client and actual dental expenditures.
- 102 (5) The division may not award contracts to:
- 103 (a) more than three responsive bidders under this section; or
- 104 (b) an insurer that does not have a current license in the state.
- 105 (6) (a) The division may cancel the request for proposals if:
- 106 (i) there are no responsive bidders; or
- 107 (ii) the division determines that accepting the bids would increase the program's costs.
- 108 (b) If the division cancels ~~[the request for proposals under]~~ a request for proposal or a
- 109 contract that results from a request for proposal described in Subsection (6)(a), the division
- 110 shall report to the Health and Human Services Interim Committee regarding the reasons for the
- 111 decision.
- 112 (7) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.
- 113 (8) (a) The division may:
- 114 (i) establish a dental health care delivery system and payment reform pilot program for
- 115 Medicaid dental benefits to increase access to cost effective and quality dental health care by
- 116 increasing the number of dentists available for Medicaid dental services; and
- 117 (ii) target specific Medicaid populations or geographic areas in the state.
- 118 (b) The pilot program shall establish compensation models for dentists and dental
- 119 hygienists that:
- 120 (i) increase access to quality, cost effective dental care; and

121 (ii) use funds from the Division of Family Health and Preparedness that are available to
 122 reimburse dentists for educational loans in exchange for the dentist agreeing to serve Medicaid
 123 and under-served populations.

124 (c) The division may amend the state plan and apply to the Secretary of Health and
 125 Human Services for waivers or pilot programs if necessary to establish the new dental care
 126 delivery and payment reform model.

127 (d) The division shall evaluate the pilot program's effect on the cost of dental care and
 128 access to dental care for the targeted Medicaid populations.

129 Section 3. Section **26-18-3.1** is amended to read:

130 **26-18-3.1. Medicaid expansion.**

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

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

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

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

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

142 (b) In order to meet the provisions of this subsection, the department may seek
 143 approval for a demonstration project under 42 U.S.C. Sec. 1315 from the secretary of the
 144 United States Department of Health and Human Services. [~~This demonstration project may
 145 also provide for the voluntary participation of private firms that:~~]

146 [~~(i) are newly established or marginally profitable;~~]

147 [~~(ii) do not provide health insurance to their employees;~~]

148 [~~(iii) employ predominantly low wage workers; and~~]

149 [~~(iv) are unable to obtain adequate and affordable health care insurance in the private
 150 market.]~~

151 (4) The Medicaid program shall provide for eligibility for persons as required by

152 Subsection 26-18-3.9(2).

153 (5) Services available for persons described in this section shall include required
154 Medicaid services and may include one or more optional Medicaid services if those services
155 are funded by the Legislature. The department may also require persons described in
156 Subsections (1) through (3) to meet an asset test.

157 Section 4. Section 26-18-3.8 is amended to read:

158 **26-18-3.8. Maximizing use of premium assistance programs -- Utah's Premium**
159 **Partnership for Health Insurance.**

160 (1) (a) The department shall seek to maximize the use of Medicaid and Children's
161 Health Insurance Program funds for assistance in the purchase of private health insurance
162 coverage for Medicaid-eligible and non-Medicaid-eligible individuals.

163 (b) The department's efforts to expand the use of premium assistance shall:

164 (i) include, as necessary, seeking federal approval under all Medicaid and Children's
165 Health Insurance Program premium assistance provisions of federal law, including provisions
166 of the Patient Protection and Affordable Care Act, Public Law 111-148;

167 (ii) give priority to, but not be limited to, expanding the state's Utah Premium
168 Partnership for Health Insurance Program, including as required under Subsection (2); and

169 (iii) encourage the enrollment of all individuals within a household in the same plan,
170 where possible, including enrollment in a plan that allows individuals within the household
171 transitioning out of Medicaid to retain the same network and benefits they had while enrolled
172 in Medicaid.

173 ~~[(c) Any increase in state costs resulting from an expansion of premium assistance may~~
174 ~~not exceed offsetting reductions in Medicaid and Children's Health Insurance Program state~~
175 ~~costs attributable to the expansion.]~~

176 (2) The department shall seek federal approval of an amendment to the state's Utah
177 Premium Partnership for Health Insurance program to adjust the eligibility determination for
178 single adults and parents who have an offer of employer sponsored insurance. The amendment
179 shall:

180 (a) be within existing appropriations for the Utah Premium Partnership for Health
181 Insurance program; and

182 (b) provide that adults who are up to 200% of the federal poverty level are eligible for

183 premium subsidies in the Utah Premium Partnership for Health Insurance program.

184 (3) For fiscal year 2021-22, the department shall seek authority to increase the
185 maximum premium subsidy per month for adults under the Utah Premium Partnership for
186 Health Insurance program to \$300.

187 (4) Beginning with fiscal year 2021-22, and in each subsequent year, the department
188 may increase premium subsidies for single adults and parents who have an offer of
189 employer-sponsored insurance to keep pace with the increase in insurance premium costs
190 subject to appropriation of additional funding.

191 Section 5. Section **26-18-3.9** is amended to read:

192 **26-18-3.9. Expanding the Medicaid program.**

193 (1) As used in this section:

194 (a) "CMS" means the Centers for Medicare and Medicaid Services in the United States
195 Department of Health and Human Services.

196 (b) "Federal poverty level" means the same as that term is defined in Section
197 [26-18-411](#).

198 (c) "Medicaid expansion" means an expansion of the Medicaid program in accordance
199 with this section.

200 (d) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in
201 Section [26-36b-208](#).

202 (2) (a) As set forth in Subsections (2) through (5), eligibility criteria for the Medicaid
203 program shall be expanded to cover additional low-income individuals.

204 (b) The department shall continue to seek approval from CMS to implement the
205 Medicaid waiver expansion as defined in Section [26-18-415](#).

206 (c) The department may implement any provision described in Subsections
207 [26-18-415](#)(2)(b)(iii) through (viii) in a Medicaid expansion if the department receives approval
208 from CMS to implement that provision.

209 (3) The department shall expand the Medicaid program in accordance with this
210 Subsection (3) if the department:

211 (a) receives approval from CMS to:

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

214 (ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(b) for
215 enrolling an individual in the Medicaid expansion under this Subsection (3); and

216 (iii) permit the state to close enrollment in the Medicaid expansion under this
217 Subsection (3) if the department has insufficient funds to provide services to new enrollment
218 under the Medicaid expansion under this Subsection (3);

219 (b) pays the state portion of costs for the Medicaid expansion under this Subsection (3)
220 with funds from:

221 (i) the Medicaid Expansion Fund;

222 (ii) county contributions to the nonfederal share of Medicaid expenditures; or

223 (iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid
224 expenditures; and

225 (c) closes the Medicaid program to new enrollment under the Medicaid expansion
226 under this Subsection (3) if the department projects that the cost of the Medicaid expansion
227 under this Subsection (3) will exceed the appropriations for the fiscal year that are authorized
228 by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter
229 1, Budgetary Procedures Act.

230 (4) (a) The department shall expand the Medicaid program in accordance with this
231 Subsection (4) if the department:

232 (i) receives approval from CMS to:

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

235 (B) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for
236 enrolling an individual in the Medicaid expansion under this Subsection (4); and

237 (C) permit the state to close enrollment in the Medicaid expansion under this
238 Subsection (4) if the department has insufficient funds to provide services to new enrollment
239 under the Medicaid expansion under this Subsection (4);

240 (ii) pays the state portion of costs for the Medicaid expansion under this Subsection (4)
241 with funds from:

242 (A) the Medicaid Expansion Fund;

243 (B) county contributions to the nonfederal share of Medicaid expenditures; or

244 (C) any other contributions, funds, or transfers from a nonstate agency for Medicaid

245 expenditures; and

246 (iii) closes the Medicaid program to new enrollment under the Medicaid expansion
247 under this Subsection (4) if the department projects that the cost of the Medicaid expansion
248 under this Subsection (4) will exceed the appropriations for the fiscal year that are authorized
249 by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter
250 1, Budgetary Procedures Act.

251 (b) The department shall submit a waiver, an amendment to an existing waiver, or a
252 state plan amendment to CMS to:

253 (i) administer federal funds for the Medicaid expansion under this Subsection (4)
254 according to a per capita cap developed by the department that includes an annual inflationary
255 adjustment, accounts for differences in cost among categories of Medicaid expansion enrollees,
256 and provides greater flexibility to the state than the current Medicaid payment model;

257 (ii) limit, in certain circumstances as defined by the department, the ability of a
258 qualified entity to determine presumptive eligibility for Medicaid coverage for an individual
259 enrolled in a Medicaid expansion under this Subsection (4);

260 (iii) impose a lock-out period if an individual enrolled in a Medicaid expansion under
261 this Subsection (4) violates certain program requirements as defined by the department;

262 (iv) allow an individual enrolled in a Medicaid expansion under this Subsection (4) to
263 remain in the Medicaid program for up to a 12-month certification period as defined by the
264 department; and

265 (v) allow federal Medicaid funds to be used for housing support for eligible enrollees
266 in the Medicaid expansion under this Subsection (4).

267 (5) (a) (i) If CMS does not approve a waiver to expand the Medicaid program in
268 accordance with Subsection (4)(a) on or before January 1, 2020, the department shall develop
269 proposals to implement additional flexibilities and cost controls, including cost sharing tools,
270 within a Medicaid expansion under this Subsection (5) through a request to CMS for a waiver
271 or state plan amendment.

272 (ii) The request for a waiver or state plan amendment described in Subsection (5)(a)(i)
273 shall include:

274 (A) a path to self-sufficiency for qualified adults in the Medicaid expansion that
275 includes employment and training as defined in 7 U.S.C. Sec. 2015(d)(4); and

276 (B) a requirement that an individual who is offered a private health benefit plan by an
277 employer to enroll in the employer's health plan.

278 (iii) The department shall submit the request for a waiver or state plan amendment
279 developed under Subsection (5)(a)(i) on or before March 15, 2020.

280 (b) Notwithstanding Sections 26-18-18 and 63J-5-204, and in accordance with this
281 Subsection (5), eligibility for the Medicaid program shall be expanded to include all persons in
282 the optional Medicaid expansion population under the Patient Protection and Affordable Care
283 Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L.
284 No. 111-152, and related federal regulations and guidance, on the earlier of:

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

287 (ii) July 1, 2020.

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

290 (i) implement each provision described in Subsections 26-18-415(2)(b)(iii) through
291 (viii) in a Medicaid expansion under this Subsection (5);

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

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

297 (d) The eligibility criteria in this Subsection (5) shall be construed to include all
298 individuals eligible for the health coverage improvement program under Section 26-18-411.

299 (e) The department shall pay the state portion of costs for a Medicaid expansion under
300 this Subsection (5) entirely from:

301 (i) the Medicaid Expansion Fund;

302 (ii) county contributions to the nonfederal share of Medicaid expenditures; or

303 (iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid
304 expenditures.

305 (f) If the costs of the Medicaid expansion under this Subsection (5) exceed the funds
306 available under Subsection (5)(e):

- 307 (i) the department may reduce or eliminate optional Medicaid services under this
308 chapter; and
- 309 (ii) savings, as determined by the department, from the reduction or elimination of
310 optional Medicaid services under Subsection (5)(f)(i) shall be deposited into the Medicaid
311 Expansion Fund; and
- 312 (iii) the department may submit to CMS a request for waivers, or an amendment of
313 existing waivers, from federal law necessary to implement budget controls within the Medicaid
314 program to address the deficiency.
- 315 (g) If the costs of the Medicaid expansion under this Subsection (5) are projected by
316 the department to exceed the funds available in the current fiscal year under Subsection (5)(e),
317 including savings resulting from any action taken under Subsection (5)(f):
- 318 (i) the governor shall direct the Department of Health, Department of Human Services,
319 and Department of Workforce Services to reduce commitments and expenditures by an amount
320 sufficient to offset the deficiency:
- 321 (A) proportionate to the share of total current fiscal year General Fund appropriations
322 for each of those agencies; and
- 323 (B) up to 10% of each agency's total current fiscal year General Fund appropriations;
324 [~~and~~]
- 325 (ii) the Division of Finance shall reduce allotments to the Department of Health,
326 Department of Human Services, and Department of Workforce Services by a percentage:
- 327 (A) proportionate to the amount of the deficiency; and
328 (B) up to 10% of each agency's total current fiscal year General Fund appropriations;
329 [~~and~~]
- 330 (iii) the Division of Finance shall deposit the total amount from the reduced allotments
331 described in Subsection (5)(g)(ii) into the Medicaid Expansion Fund.
- 332 (6) The department shall maximize federal financial participation in implementing this
333 section, including by seeking to obtain any necessary federal approvals or waivers.
- 334 (7) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
335 provide matching funds to the state for the cost of providing Medicaid services to newly
336 enrolled individuals who qualify for Medicaid coverage under a Medicaid expansion.
- 337 (8) The department shall report to the Social Services Appropriations Subcommittee on

338 or before November 1 of each year that a Medicaid expansion is operational:

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

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

341 (c) estimated costs to the state for the Medicaid expansion for the current and

342 following fiscal years; ~~and~~

343 (d) recommendations to control costs of the Medicaid expansion~~[-]; and~~

344 (e) as calculated in accordance with Subsections 26-36b-204(4) and 26-36c-204(2), the
345 state's net cost of the qualified Medicaid expansion.

346 Section 6. Section 26-18-5 is amended to read:

347 **26-18-5. Contracts for provision of medical services -- Federal provisions**

348 **modifying department rules -- Compliance with Social Security Act.**

349 (1) The department may contract with other public or private agencies to purchase or
350 provide medical services in connection with the programs of the division. Where these
351 programs are used by other ~~[state agencies]~~ government entities, contracts shall provide that
352 other ~~[state agencies]~~ government entities, in compliance with state and federal law regarding
353 intergovernmental transfers, transfer the state matching funds to the department in amounts
354 sufficient to satisfy needs of the specified program.

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

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

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

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

365 Section 7. Section 26-18-8 is amended to read:

366 **26-18-8. Enforcement of public assistance statutes.**

367 (1) The department shall enforce or contract for the enforcement of Sections
368 35A-1-503, 35A-3-108, 35A-3-110, 35A-3-111, 35A-3-112, and 35A-3-603 ~~[insofar as]~~ to the

369 extent that these sections pertain to benefits conferred or administered by the division under
370 this chapter, to the extent allowed under federal law or regulation.

371 (2) The department may contract for services covered in Section 35A-3-111 insofar as
372 that section pertains to benefits conferred or administered by the division under this chapter.

373 Section 8. Section 26-18-103 is amended to read:

374 **26-18-103. DUR Board -- Responsibilities.**

375 The board shall:

376 (1) develop rules necessary to carry out its responsibilities as defined in this part;

377 (2) oversee the implementation of a Medicaid retrospective and prospective DUR
378 program in accordance with this part, including responsibility for approving provisions of
379 contractual agreements between the Medicaid program and any other entity that will process
380 and review Medicaid drug claims and profiles for the DUR program in accordance with this
381 part;

382 (3) develop and apply predetermined criteria and standards to be used in retrospective
383 and prospective DUR, ensuring that the criteria and standards are based on the compendia, and
384 that they are developed with professional input, in a consensus fashion, with provisions for
385 timely revision and assessment as necessary. The DUR standards developed by the board shall
386 reflect the local practices of physicians in order to monitor:

387 (a) therapeutic appropriateness;

388 (b) overutilization or underutilization;

389 (c) therapeutic duplication;

390 (d) drug-disease contraindications;

391 (e) drug-drug interactions;

392 (f) incorrect drug dosage or duration of drug treatment; and

393 (g) clinical abuse and misuse;

394 (4) develop, select, apply, and assess interventions and remedial strategies for
395 physicians, pharmacists, and recipients that are educational and not punitive in nature, in order
396 to improve the quality of care;

397 (5) disseminate information to physicians and pharmacists to ensure that they are aware
398 of the board's duties and powers;

399 (6) provide written, oral, or electronic reminders of patient-specific or drug-specific

400 information, designed to ensure recipient, physician, and pharmacist confidentiality, and
401 suggest changes in prescribing or dispensing practices designed to improve the quality of care;

402 (7) utilize face-to-face discussions between experts in drug therapy and the prescriber
403 or pharmacist who has been targeted for educational intervention;

404 (8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;

405 (9) create an educational program using data provided through DUR to provide active
406 and ongoing educational outreach programs to improve prescribing and dispensing practices,
407 either directly or by contract with other governmental or private entities;

408 (10) provide a timely evaluation of intervention to determine if those interventions
409 have improved the quality of care;

410 ~~[(11) publish an annual report, subject to public comment prior to its issuance, and~~
411 ~~submit that report to the United States Department of Health and Human Services by~~
412 ~~December 1 of each year. That report shall also be submitted to the executive director, the~~
413 ~~president of the Utah Pharmaceutical Association, and the president of the Utah Medical~~
414 ~~Association by December 1 of each year. The report shall include:]~~

415 ~~[(a) an overview of the activities of the board and the DUR program;]~~

416 ~~[(b) a description of interventions used and their effectiveness, specifying whether the~~
417 ~~intervention was a result of underutilization or overutilization of drugs, without disclosing the~~
418 ~~identities of individual physicians, pharmacists, or recipients;]~~

419 ~~[(c) the costs of administering the DUR program;]~~

420 ~~[(d) any fiscal savings resulting from the DUR program;]~~

421 ~~[(e) an overview of the fiscal impact of the DUR program to other areas of the~~
422 ~~Medicaid program such as hospitalization or long-term care costs;]~~

423 ~~[(f) a quantifiable assessment of whether DUR has improved the recipient's quality of~~
424 ~~care;]~~

425 ~~[(g) a review of the total number of prescriptions, by drug therapeutic class;]~~

426 ~~[(h) an assessment of the impact of educational programs or interventions on~~
427 ~~prescribing or dispensing practices; and]~~

428 ~~[(i) recommendations for DUR program improvement;]~~

429 (11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec.

430 712;

431 (12) develop a working agreement with related boards or agencies, including the State
432 Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order
433 to clarify areas of responsibility for each, where those areas may overlap;

434 (13) establish a grievance process for physicians and pharmacists under this part, in
435 accordance with Title 63G, Chapter 4, Administrative Procedures Act;

436 (14) publish and disseminate educational information to physicians and pharmacists
437 concerning the board and the DUR program, including information regarding:

438 (a) identification and reduction of the frequency of patterns of fraud, abuse, gross
439 overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and
440 recipients;

441 (b) potential or actual severe or adverse reactions to drugs;

442 (c) therapeutic appropriateness;

443 (d) overutilization or underutilization;

444 (e) appropriate use of generics;

445 (f) therapeutic duplication;

446 (g) drug-disease contraindications;

447 (h) drug-drug interactions;

448 (i) incorrect drug dosage and duration of drug treatment;

449 (j) drug allergy interactions; and

450 (k) clinical abuse and misuse;

451 (15) develop and publish, with the input of the State Board of Pharmacy, guidelines
452 and standards to be used by pharmacists in counseling Medicaid recipients in accordance with
453 this part. The guidelines shall ensure that the recipient may refuse counseling and that the
454 refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling
455 include:

456 (a) the name and description of the medication;

457 (b) administration, form, and duration of therapy;

458 (c) special directions and precautions for use;

459 (d) common severe side effects or interactions, and therapeutic interactions, and how to
460 avoid those occurrences;

461 (e) techniques for self-monitoring drug therapy;

462 (f) proper storage;
 463 (g) prescription refill information; and
 464 (h) action to be taken in the event of a missed dose; and
 465 (16) establish procedures in cooperation with the State Board of Pharmacy for
 466 pharmacists to record information to be collected under this part. The recorded information
 467 shall include:

468 (a) the name, address, age, and gender of the recipient;
 469 (b) individual history of the recipient where significant, including disease state, known
 470 allergies and drug reactions, and a comprehensive list of medications and relevant devices;
 471 (c) the pharmacist's comments on the individual's drug therapy;
 472 (d) name of prescriber; and
 473 (e) name of drug, dose, duration of therapy, and directions for use.

474 Section 9. Section **26-18-408** is amended to read:

475 **26-18-408. Incentives to appropriately use emergency department services.**

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

478 (b) ~~[For purposes of]~~ As used in this section:

479 (i) ~~["Accountable"]~~ "Managed care organization" means a ~~[Medicaid or Children's~~
 480 ~~Health Insurance Program administrator]~~ comprehensive full risk managed care delivery
 481 system that contracts with the Medicaid program or the Children's Health Insurance Program to
 482 deliver health care through ~~[an accountable]~~ a managed care plan.

483 (ii) ~~["Accountable"]~~ "Managed care plan" means a ~~[risk-based]~~ risk-based delivery
 484 service model authorized by Section **26-18-405** and administered by ~~[an accountable]~~ a
 485 managed care organization.

486 (iii) ~~["Nonemergent"]~~ "Non-emergent care":

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

491 (B) does not mean the medical services provided to ~~[a recipient]~~ an individual required
 492 by the Emergency Medical Treatment and Active Labor Act, including services to conduct a

493 medical screening examination to determine if the recipient has an emergent or [~~nonemergent~~]
494 non-emergent condition.

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

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

500 (2) (a) [~~An accountable~~] A managed care organization may, in accordance with
501 Subsections (2)(b) and (c):

502 (i) audit emergency department services provided to a recipient enrolled in the
503 [~~accountable~~] managed care plan to determine if [~~nonemergent~~] non-emergent care was
504 provided to the recipient; and

505 (ii) establish differential payment for emergent and [~~nonemergent~~] non-emergent care
506 provided in an emergency department.

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

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

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

517 (3) [~~An accountable~~] A managed care organization shall:

518 (a) use the savings under Subsection (2) to maintain and improve access to primary
519 care and urgent care services for all [~~of the~~] Medicaid or CHIP recipients enrolled in the
520 [~~accountable~~] managed care plan;

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

523 (c) report to the department on how the [~~accountable~~] managed care organization

524 complied with this Subsection (3).

525 (4) The department ~~[shall]~~ may:

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

528 (i) appropriate emergency department services to recipients enrolled in the
529 ~~[accountable]~~ managed care plan;

530 (ii) expanded primary care and urgent care for recipients enrolled in the ~~[accountable]~~
531 managed care plan, with consideration of the ~~[accountable]~~ managed care organization's:

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

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

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

537 (iii) quality of care for the ~~[accountable]~~ managed care plan members;

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

542 ~~[(c) apply for a Medicaid waiver and a Children's Health Insurance Program waiver~~
543 ~~with CMS, to:]~~

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

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

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

553 ~~[(i) creating increased access to primary care services;]~~

554 ~~[(ii) alternative care settings for super-utilizers and individuals with behavioral health~~

555 or substance abuse issues;]

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

559 ~~[(iv) case management programs that can:]~~

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

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

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

566 ~~[(v) sharing of medical records between health care providers and emergency~~
567 ~~departments for Medicaid recipients;]~~

568 ~~[(5) The Health Data Committee may publish data in accordance with Chapter 33a,~~
569 ~~Utah Health Data Authority Act, which compares the quality measures for the accountable care~~
570 ~~plans;]~~

571 Section 10. Section **26-18-411** is amended to read:

572 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
573 **-- Expansion of eligibility for adults with dependent children.**

574 (1) For purposes of this section:

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

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

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

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

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

583 (d) "Health coverage improvement program" means the health coverage improvement
584 program described in Subsections (3) through (10).

585 (e) "Homeless":

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

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

590 (f) "Income eligibility ceiling" means the percent of federal poverty level:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

636 (i) a chronically homeless individual;

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

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

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

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

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

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

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

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

655 and

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

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

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

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

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

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

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

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

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

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

684 Section 11. Section **26-18-413** is amended to read:

685 **26-18-413. Medicaid waiver for delivery of adult dental services.**

686 (1) (a) Before June 30, 2016, the department shall ask CMS to grant waivers from
687 federal statutory and regulatory law necessary for the Medicaid program to provide dental
688 services in the manner described in Subsection (2)(a).

689 (b) Before June 30, 2018, the department shall submit to CMS a request for waivers, or
690 an amendment of existing waivers, from federal law necessary for the state to provide dental
691 services, in accordance with Subsections (2)(b)(i) and (d) through (g), to an individual
692 described in Subsection (2)(b)(i).

693 (c) Before June 30, 2019, the department shall submit to the Centers for Medicare and
694 Medicaid Services a request for waivers, or an amendment to existing waivers, from federal
695 law necessary for the state to:

696 (i) provide dental services, in accordance with Subsections (2)(b)(ii) and (d) through
697 (g) to an individual described in Subsection (2)(b)(ii); and

698 (ii) provide the services described in Subsection (2)(h).

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

702 (b) Notwithstanding Subsection (2)(a):

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

705 (A) qualifies for the health coverage improvement program described in Section
706 [26-18-411](#); and

707 (B) is receiving treatment in a substance abuse treatment program, as defined in
708 Section [62A-2-101](#), licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities;
709 and

710 (ii) if a waiver is approved under Subsection (1)(c)(i), the department shall provide
711 dental services to an individual who is an aged individual as defined in 42 U.S.C. Sec.
712 1382c(a)(1).

713 (c) To the extent possible, services to individuals described in Subsection (2)(a) shall
714 be provided through the University of Utah School of Dentistry and the University of Utah
715 School of Dentistry's associated statewide network.

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

718 (i) by contracting with an entity that:

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

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

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

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

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

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

731 (f) Each fiscal year, the University of Utah School of Dentistry shall [~~transfer money~~],
732 in compliance with state and federal regulations regarding intergovernmental transfers, transfer
733 funds to the program in an amount equal to the program's non-federal share of the cost of
734 providing services under this section through the school during the fiscal year.

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

739 [(~~h~~) (g) If a waiver is approved under Subsection (1)(c)(ii), the department shall
740 provide coverage for porcelain and porcelain-to-metal crowns if the services are provided:

741 (i) to an individual who qualifies for dental services under Subsection (2)(b); and

742 (ii) by an entity that covers all state costs of:

743 (A) providing the coverage described in this Subsection (2)(h); and

744 (B) applying for the waiver described in Subsection (1)(c)[(ii)].

745 [(i)] (h) Where possible, the department shall ensure that services described in

746 Subsection (2)(a) that are not provided by the University of Utah School of Dentistry or the

747 University of Utah School of Dentistry's associated network are provided:

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

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

751 [(j)] (i) Subject to appropriations by the Legislature, and as determined by the

752 department, the scope, amount, duration, and frequency of services may be limited.

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

755 [(4)] (3) (a) If the waivers requested under Subsection (1)(a) are granted, the Medicaid

756 program shall begin providing dental services in the manner described in Subsection (2) no

757 later than July 1, 2017.

758 (b) If the waivers requested under Subsection (1)(b) are granted, the Medicaid program

759 shall begin providing dental services to the population described in Subsection (2)(b) within 90

760 days from the day on which the waivers are granted.

761 (c) If the waivers requested under Subsection (1)(c)(i) are granted, the Medicaid

762 program shall begin providing dental services to the population described in Subsection

763 (2)(b)(ii) within 90 days after the day on which the waivers are granted.

764 [(5)] (4) If the federal share of the cost of providing dental services under this section

765 will be less than 65% during any portion of the next fiscal year, the Medicaid program shall

766 cease providing dental services under this section no later than the end of the current fiscal

767 year.

768 Section 12. Section **26-36b-204** is amended to read:

769 **26-36b-204. Hospital financing of health coverage improvement program**

770 **Medicaid waiver expansion -- Hospital share.**

771 (1) The hospital share is:

772 (a) 45% of the state's net cost of the health coverage improvement program, including
773 Medicaid coverage for individuals with dependent children up to the federal poverty level
774 designated under Section [26-18-411](#);

775 (b) 45% of the state's net cost of the enhancement waiver program;

776 (c) if the waiver for the Medicaid waiver expansion is approved, \$11,900,000; and

777 (d) 45% of the state's net cost of the upper payment limit gap.

778 (2) (a) The hospital share is capped at no more than \$13,600,000 annually, consisting
779 of:

780 (i) an \$11,900,000 cap for the programs specified in Subsections (1)(a) through (c);

781 and

782 (ii) a \$1,700,000 cap for the program specified in Subsection (1)(d).

783 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in
784 which the programs specified in Subsections (1)(a) and (d) are not in effect for the full fiscal
785 year.

786 (3) Private hospitals shall be assessed under this chapter for:

787 (a) 69% of the portion of the hospital share for the programs specified in Subsections
788 (1)(a) through (c); and

789 (b) 100% of the portion of the hospital share specified in Subsection (1)(d).

790 (4) (a) [~~The department shall, on or before October 15, 2017, and on or before October~~
791 ~~15 of each subsequent year, produce a report that calculates~~] In the report described in
792 Subsection [26-18-3.9\(8\)](#), the department shall calculate the state's net cost of each of the
793 programs described in Subsections (1)(a) through (c) that are in effect for that year.

794 (b) If the assessment collected in the previous fiscal year is above or below the hospital
795 share for private hospitals for the previous fiscal year, the underpayment or overpayment of the
796 assessment by the private hospitals shall be applied to the fiscal year in which the report is
797 issued.

798 (5) A Medicaid accountable care organization shall, on or before October 15 of each
799 year, report to the department the following data from the prior state fiscal year for each private
800 hospital, state teaching hospital, and non-state government hospital provider that the Medicaid
801 accountable care organization contracts with:

802 (a) for the traditional Medicaid population:

803 (i) hospital inpatient payments;
 804 (ii) hospital inpatient discharges;
 805 (iii) hospital inpatient days; and
 806 (iv) hospital outpatient payments; and
 807 (b) if the Medicaid accountable care organization enrolls any individuals in the health
 808 coverage improvement program, the enhancement waiver program, or the Medicaid waiver
 809 expansion, for the population newly eligible for any of those programs:

810 (i) hospital inpatient payments;
 811 (ii) hospital inpatient discharges;
 812 (iii) hospital inpatient days; and
 813 (iv) hospital outpatient payments.

814 (6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
 815 Administrative Rulemaking Act, provide details surrounding specific content and format for
 816 the reporting by the Medicaid accountable care organization.

817 Section 13. Section **26-36b-205** is amended to read:

818 **26-36b-205. Calculation of assessment.**

819 (1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a
 820 quarterly basis for each private hospital in an amount calculated by the division at a uniform
 821 assessment rate for each hospital discharge, in accordance with this section.

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

824 (c) The division shall calculate the uniform assessment rate described in Subsection
 825 (1)(a) by dividing the hospital share for assessed private hospitals, described in [~~Subsection~~
 826 ~~26-36b-204(1)~~] Subsections 26-36b-204(1) and 26-36b-204(3), by the sum of:

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

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

831 (d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah
 832 Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address
 833 unforeseen circumstances in the administration of the assessment under this chapter.

834 (e) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
835 all assessed private hospitals.

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

838 (a) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year
839 ending between July 1, 2013, and June 30, 2014; and

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

842 (3) (a) If a hospital's fiscal year Medicare cost report is not contained in the CMS
843 Healthcare Cost Report Information System file:

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

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

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

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

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

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

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

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

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

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

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

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

864 Section 14. Section **26-36c-204** is amended to read:

865 **26-36c-204. Hospital financing.**

866 (1) Private hospitals shall be assessed under this chapter for the portion of the hospital
867 share described in Section [26-36c-209](#).

868 (2) [~~The department shall, on or before October 15, 2020, and on or before October 15~~
869 ~~of each subsequent year, produce a report that calculates~~] In the report described in Subsection
870 [26-18-3.9\(8\)](#), the department shall calculate the state's net cost of the qualified Medicaid
871 expansion.

872 (3) If the assessment collected in the previous fiscal year is above or below the hospital
873 share for private hospitals for the previous fiscal year, the division shall apply the
874 underpayment or overpayment of the assessment by the private hospitals to the fiscal year in
875 which the report is issued.

876 Section 15. Section **26-40-106** is amended to read:

877 **26-40-106. Program benefits.**

878 (1) Except as provided in Subsection (3), medical and dental program benefits shall be
879 benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, as follows:

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

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

884 (ii) comply with the Mental Health Parity and Addiction Equity Act, Pub. L. No.
885 110-343; and

886 (b) dental program benefits shall be benchmarked ~~[on]~~ effective July 1, 2019, and on
887 July 1 every third year thereafter in accordance with the Children's Health Insurance Program
888 Reauthorization Act of 2009, to be substantially equal to a dental benefit plan that has the
889 largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the
890 state, except that the utilization review mechanism for orthodontia shall be based on medical
891 necessity.

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

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

896 Section 16. Section **62A-2-120** is amended to read:

897 **62A-2-120. Background check -- Direct access to children or vulnerable adults.**

898 (1) As used in this section:

899 (a) (i) "Applicant" means:

900 (A) the same as that term is defined in Section [62A-2-101](#);

901 (B) an individual who is associated with a licensee and has or will likely have direct
902 access to a child or a vulnerable adult;

903 (C) an individual who provides respite care to a foster parent or an adoptive parent on
904 more than one occasion;

905 (D) a department contractor;

906 (E) a guardian submitting an application on behalf of an individual, other than the child
907 or vulnerable adult who is receiving the service, if the individual is 12 years of age or older and
908 resides in a home, that is licensed or certified by the office, with the child or vulnerable adult
909 who is receiving services; or

910 (F) a guardian submitting an application on behalf of an individual, other than the child
911 or vulnerable adult who is receiving the service, if the individual is 12 years of age or older and
912 is a person described in Subsection (1)(a)(i)(A), (B), (C), or (D).

913 (ii) "Applicant" does not mean an individual, including an adult, who is in the custody
914 of the Division of Child and Family Services or the Division of Juvenile Justice Services.

915 (b) "Application" means a background screening application to the office.

916 (c) "Bureau" means the Bureau of Criminal Identification within the Department of
917 Public Safety, created in Section [53-10-201](#).

918 (d) "Incidental care" means occasional care, not in excess of five hours per week and
919 never overnight, for a foster child.

920 (e) "Personal identifying information" means:

921 (i) current name, former names, nicknames, and aliases;

922 (ii) date of birth;

923 (iii) physical address and email address;

924 (iv) telephone number;

925 (v) driver license or other government-issued identification;

926 (vi) social security number;

927 (vii) only for applicants who are 18 years of age or older, fingerprints, in a form
928 specified by the office; and

929 (viii) other information specified by the office by rule made in accordance with Title
930 63G, Chapter 3, Utah Administrative Rulemaking Act.

931 (2) (a) Except as provided in Subsection (13), an applicant or a representative shall
932 submit the following to the office:

933 (i) personal identifying information;

934 (ii) a fee established by the office under Section 63J-1-504; and

935 (iii) a disclosure form, specified by the office, for consent for:

936 (A) an initial background check upon submission of the information described under
937 this Subsection (2)(a);

938 [~~(B) a background check at the applicant's annual renewal;~~]

939 (B) ongoing monitoring of fingerprints and registries until no longer associated with a
940 licensee for 90 days;

941 (C) a background check when the office determines that reasonable cause exists; and

942 (D) retention of personal identifying information, including fingerprints, for

943 monitoring and notification as described in Subsections (3)(d) and (4).

944 (b) In addition to the requirements described in Subsection (2)(a), if an applicant [~~spent~~
945 time] resided outside of the United States and its territories during the five years immediately
946 preceding the day on which the information described in Subsection (2)(a) is submitted to the
947 office, the office may require the applicant to submit documentation establishing whether the
948 applicant was convicted of a crime during the time that the applicant [~~spent~~] resided outside of
949 the United States or its territories.

950 (3) The office:

951 (a) shall perform the following duties as part of a background check of an applicant:

952 (i) check state and regional criminal background databases for the applicant's criminal
953 history by:

954 (A) submitting personal identifying information to the bureau for a search; or

955 (B) using the applicant's personal identifying information to search state and regional
956 criminal background databases as authorized under Section 53-10-108;

957 (ii) submit the applicant's personal identifying information and fingerprints to the

958 bureau for a criminal history search of applicable national criminal background databases;
959 (iii) search the Department of Human Services, Division of Child and Family Services'
960 Licensing Information System described in Section [62A-4a-1006](#);
961 (iv) search the Department of Human Services, Division of Aging and Adult Services'
962 vulnerable adult abuse, neglect, or exploitation database described in Section [62A-3-311.1](#);
963 (v) search the juvenile court records for substantiated findings of severe child abuse or
964 neglect described in Section [78A-6-323](#); and
965 (vi) search the juvenile court arrest, adjudication, and disposition records, as provided
966 under Section [78A-6-209](#);
967 (b) shall conduct a background check of an applicant for an initial background check
968 upon submission of the information described under Subsection (2)(a);
969 (c) may conduct all or portions of a background check of an applicant, as provided by
970 rule, made by the office in accordance with Title 63G, Chapter 3, Utah Administrative
971 Rulemaking Act:
972 (i) for an annual renewal; or
973 (ii) when the office determines that reasonable cause exists;
974 (d) may submit an applicant's personal identifying information, including fingerprints,
975 to the bureau for checking, retaining, and monitoring of state and national criminal background
976 databases and for notifying the office of new criminal activity associated with the applicant;
977 (e) shall track the status of an approved applicant under this section to ensure that an
978 approved applicant is not required to duplicate the submission of the applicant's fingerprints if
979 the applicant applies for:
980 (i) more than one license;
981 (ii) direct access to a child or a vulnerable adult in more than one human services
982 program; or
983 (iii) direct access to a child or a vulnerable adult under a contract with the department;
984 (f) shall track the status of each license and each individual with direct access to a child
985 or a vulnerable adult and notify the bureau [~~when the license has expired~~] within 90 days after
986 the day on which the license expires or the individual's direct access to a child or a vulnerable
987 adult [~~has ceased~~] ceases;
988 (g) shall adopt measures to strictly limit access to personal identifying information

989 solely to the [~~office employees~~] individuals responsible for processing and entering the
990 applications for background checks and to protect the security of the personal identifying
991 information the office reviews under this Subsection (3);

992 (h) as necessary to comply with the federal requirement to check a state's child abuse
993 and neglect registry regarding any individual working in a program under this section that
994 serves children, shall:

995 (i) search the Department of Human Services, Division of Child and Family Services'
996 Licensing Information System described in Section [62A-4a-1006](#); and

997 (ii) require the child abuse and neglect registry be checked in each state where an
998 applicant resided at any time during the five years immediately preceding the day on which the
999 applicant submits the information described in Subsection (2)(a) to the office; and

1000 (i) shall make rules, in accordance with Title 63G, Chapter 3, Utah Administrative
1001 Rulemaking Act, to implement the provisions of this Subsection (3) relating to background
1002 checks.

1003 (4) (a) With the personal identifying information the office submits to the bureau under
1004 Subsection (3), the bureau shall check against state and regional criminal background databases
1005 for the applicant's criminal history.

1006 (b) With the personal identifying information and fingerprints the office submits to the
1007 bureau under Subsection (3), the bureau shall check against national criminal background
1008 databases for the applicant's criminal history.

1009 (c) Upon direction from the office, and with the personal identifying information and
1010 fingerprints the office submits to the bureau under Subsection (3)(d), the bureau shall:

1011 (i) maintain a separate file of the fingerprints for search by future submissions to the
1012 local and regional criminal records databases, including latent prints; and

1013 (ii) monitor state and regional criminal background databases and identify criminal
1014 activity associated with the applicant.

1015 (d) The bureau is authorized to submit the fingerprints to the Federal Bureau of
1016 Investigation Next Generation Identification System, to be retained in the Federal Bureau of
1017 Investigation Next Generation Identification System for the purpose of:

1018 (i) being searched by future submissions to the national criminal records databases,
1019 including the Federal Bureau of Investigation Next Generation Identification System and latent

1020 prints; and

1021 (ii) monitoring national criminal background databases and identifying criminal
1022 activity associated with the applicant.

1023 (e) The Bureau shall notify and release to the office all information of criminal activity
1024 associated with the applicant.

1025 (f) Upon notice from the office that a license has expired or an individual's direct
1026 access to a child or a vulnerable adult has ceased for 90 days, the bureau shall:

1027 (i) discard and destroy any retained fingerprints; and

1028 (ii) notify the Federal Bureau of Investigation when the license has expired or an
1029 individual's direct access to a child or a vulnerable adult has ceased, so that the Federal Bureau
1030 of Investigation will discard and destroy the retained fingerprints from the Federal Bureau of
1031 Investigation Next Generation Identification System.

1032 (5) (a) After conducting the background check described in Subsections (3) and (4), the
1033 office shall deny an application to an applicant who, within three years before the day on which
1034 the applicant submits information to the office under Subsection (2) for a background check,
1035 has been convicted of any of the following, regardless of whether the offense is a felony, a
1036 misdemeanor, or an infraction:

1037 (i) an offense identified as domestic violence, lewdness, voyeurism, battery, cruelty to
1038 animals, or bestiality;

1039 (ii) a violation of any pornography law, including sexual exploitation of a minor;

1040 (iii) prostitution;

1041 (iv) an offense included in:

1042 (A) Title 76, Chapter 5, Offenses Against the Person;

1043 (B) Section 76-5b-201, Sexual Exploitation of a Minor; or

1044 (C) Title 76, Chapter 7, Offenses Against the Family;

1045 (v) aggravated arson, as described in Section 76-6-103;

1046 (vi) aggravated burglary, as described in Section 76-6-203;

1047 (vii) aggravated robbery, as described in Section 76-6-302;

1048 (viii) identity fraud crime, as described in Section 76-6-1102; or

1049 (ix) a conviction for a felony or misdemeanor offense committed outside of the state
1050 that, if committed in the state, would constitute a violation of an offense described in

1051 Subsections (5)(a)(i) through (viii).

1052 (b) If the office denies an application to an applicant based on a conviction described in
1053 Subsection (5)(a), the applicant is not entitled to a comprehensive review described in
1054 Subsection (6).

1055 (c) If the applicant will be working in a program serving only adults whose only
1056 impairment is a mental health diagnosis, including that of a serious mental health disorder,
1057 with or without co-occurring substance use disorder, the denial provisions of Subsection (5)(a)
1058 do not apply, and the office shall conduct a comprehensive review as described in Subsection
1059 (6).

1060 (6) (a) The office shall conduct a comprehensive review of an applicant's background
1061 check if the applicant:

1062 (i) has an open court case or a conviction for any felony offense, not described in
1063 Subsection (5)(a), ~~[regardless of the date of the conviction]~~ with a date of conviction that is no
1064 more than 10 years before the date on which the applicant submits the application;

1065 (ii) has an open court case or a conviction for a misdemeanor offense, not described in
1066 Subsection (5)(a), and designated by the office, by rule, in accordance with Title 63G, Chapter
1067 3, Utah Administrative Rulemaking Act, if the conviction is within ~~[five]~~ three years before the
1068 day on which the applicant submits information to the office under Subsection (2) for a
1069 background check;

1070 (iii) has a conviction for any offense described in Subsection (5)(a) that occurred more
1071 than three years before the day on which the applicant submitted information under Subsection
1072 (2)(a);

1073 (iv) is currently subject to a plea in abeyance or diversion agreement for any offense
1074 described in Subsection (5)(a);

1075 (v) has a listing in the Department of Human Services, Division of Child and Family
1076 Services' Licensing Information System described in Section [62A-4a-1006](#);

1077 (vi) has a listing in the Department of Human Services, Division of Aging and Adult
1078 Services' vulnerable adult abuse, neglect, or exploitation database described in Section
1079 [62A-3-311.1](#);

1080 (vii) has a record in the juvenile court of a substantiated finding of severe child abuse
1081 or neglect described in Section [78A-6-323](#);

1082 (viii) has a record of an adjudication in juvenile court for an act that, if committed by
1083 an adult, would be a felony or misdemeanor, if the applicant is:

1084 (A) under 28 years of age; or

1085 (B) 28 years of age or older and has been convicted of, has pleaded no contest to, or is
1086 currently subject to a plea in abeyance or diversion agreement for a felony or a misdemeanor
1087 offense described in Subsection (5)(a); [~~or~~]

1088 (ix) has a pending charge for an offense described in Subsection (5)(a)~~[-];~~ or

1089 (x) is an applicant described in Subsection (5)(c).

1090 (b) The comprehensive review described in Subsection (6)(a) shall include an
1091 examination of:

1092 (i) the date of the offense or incident;

1093 (ii) the nature and seriousness of the offense or incident;

1094 (iii) the circumstances under which the offense or incident occurred;

1095 (iv) the age of the perpetrator when the offense or incident occurred;

1096 (v) whether the offense or incident was an isolated or repeated incident;

1097 (vi) whether the offense or incident directly relates to abuse of a child or vulnerable
1098 adult, including:

1099 (A) actual or threatened, nonaccidental physical [~~or~~], mental, or financial harm;

1100 (B) sexual abuse;

1101 (C) sexual exploitation; or

1102 (D) negligent treatment;

1103 (vii) any evidence provided by the applicant of rehabilitation, counseling, psychiatric
1104 treatment received, or additional academic or vocational schooling completed; [~~and~~]

1105 (viii) the applicant's risk of harm to clientele in the program or in the capacity for
1106 which the applicant is applying; and

1107 [~~(viii)~~] (ix) any other pertinent information presented to or publicly available to the
1108 committee members.

1109 (c) At the conclusion of the comprehensive review described in Subsection (6)(a), the
1110 office shall deny an application to an applicant if the office finds that approval would likely
1111 create a risk of harm to a child or a vulnerable adult.

1112 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

1113 office may make rules, consistent with this chapter, to establish procedures for the
1114 comprehensive review described in this Subsection (6).

1115 (7) Subject to Subsection (10), the office shall approve an application to an applicant
1116 who is not denied under Subsection (5), (6), or (13).

1117 (8) (a) The office may conditionally approve an application of an applicant, for a
1118 maximum of 60 days after the day on which the office sends written notice to the applicant
1119 under Subsection (12), without requiring that the applicant be directly supervised, if the office:

1120 (i) is awaiting the results of the criminal history search of national criminal background
1121 databases; and

1122 (ii) would otherwise approve an application of the applicant under Subsection (7).

1123 (b) The office may conditionally approve an application of an applicant, for a
1124 maximum of one year after the day on which the office sends written notice to the applicant
1125 under Subsection (12), without requiring that the applicant be directly supervised if the office:

1126 (i) is awaiting the results of an out-of-state registry for providers other than foster and
1127 adoptive parents; and

1128 (ii) would otherwise approve an application of the applicant under Subsection (7).

1129 ~~[(b)]~~ (c) Upon receiving the results of the criminal history search of a national criminal
1130 background ~~[databases]~~ database, the office shall approve or deny the application of the
1131 applicant in accordance with Subsections (5) through (7).

1132 (9) A licensee or department contractor may not permit an individual to have direct
1133 access to a child or a vulnerable adult unless, subject to Subsection (10):

1134 (a) the individual is associated with the licensee or department contractor and:

1135 (i) the individual's application is approved by the office under this section;

1136 (ii) the individual's application is conditionally approved by the office under

1137 Subsection (8); or

1138 (iii) (A) the individual has submitted the background check information described in
1139 Subsection (2) to the office;

1140 (B) the office has not determined whether to approve the applicant's application; and

1141 (C) the individual is directly supervised by an individual who has a current background
1142 screening approval issued by the office under this section and is associated with the licensee or
1143 department contractor;

- 1144 (b) (i) the individual is associated with the licensee or department contractor;
- 1145 (ii) the individual has a current background screening approval issued by the office
- 1146 under this section;
- 1147 (iii) one of the following circumstances, that the office has not yet reviewed under
- 1148 Subsection (6), applies to the individual:
- 1149 (A) the individual was charged with an offense described in Subsection (5)(a);
- 1150 (B) the individual is listed in the Licensing Information System, described in Section
- 1151 [62A-4a-1006](#);
- 1152 (C) the individual is listed in the vulnerable adult abuse, neglect, or exploitation
- 1153 database, described in Section [62A-3-311.1](#);
- 1154 (D) the individual has a record in the juvenile court of a substantiated finding of severe
- 1155 child abuse or neglect, described in Section [78A-6-323](#); or
- 1156 (E) the individual has a record of an adjudication in juvenile court for an act that, if
- 1157 committed by an adult, would be a felony or a misdemeanor as described in Subsection (5)(a)
- 1158 or (6); and
- 1159 (iv) the individual is directly supervised by an individual who:
- 1160 (A) has a current background screening approval issued by the office under this
- 1161 section; and
- 1162 (B) is associated with the licensee or department contractor;
- 1163 (c) the individual:
- 1164 (i) is not associated with the licensee or department contractor; and
- 1165 (ii) is directly supervised by an individual who:
- 1166 (A) has a current background screening approval issued by the office under this
- 1167 section; and
- 1168 (B) is associated with the licensee or department contractor;
- 1169 (d) the individual is the parent or guardian of the child, or the guardian of the
- 1170 vulnerable adult;
- 1171 (e) the individual is approved by the parent or guardian of the child, or the guardian of
- 1172 the vulnerable adult, to have direct access to the child or the vulnerable adult;
- 1173 (f) the individual is only permitted to have direct access to a vulnerable adult who
- 1174 voluntarily invites the individual to visit; or

1175 (g) the individual only provides incidental care for a foster child on behalf of a foster
1176 parent who has used reasonable and prudent judgment to select the individual to provide the
1177 incidental care for the foster child.

1178 (10) An individual may not have direct access to a child or a vulnerable adult if the
1179 individual is prohibited by court order from having that access.

1180 (11) Notwithstanding any other provision of this section, an individual for whom the
1181 office denies an application may not have [~~supervised or unsupervised~~] direct access to a child
1182 or vulnerable adult unless the office approves a subsequent application by the individual.

1183 (12) (a) Within 30 days after the day on which the office receives the background
1184 check information for an applicant, the office shall give [~~written~~] notice of the clearance status
1185 to:

1186 (i) the applicant, and the licensee or department contractor, of the office's decision
1187 regarding the background check and findings; and

1188 (ii) the applicant of any convictions and potentially disqualifying charges and
1189 adjudications found in the search.

1190 (b) With the notice described in Subsection (12)(a), the office shall also give the
1191 applicant the details of any comprehensive review conducted under Subsection (6).

1192 (c) If the notice under Subsection (12)(a) states that the applicant's application is
1193 denied, the notice shall further advise the applicant that the applicant may, under Subsection
1194 [62A-2-111\(2\)](#), request a hearing in the department's Office of Administrative Hearings, to
1195 challenge the office's decision.

1196 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
1197 office shall make rules, consistent with this chapter:

1198 (i) defining procedures for the challenge of its background check decision described in
1199 Subsection (12)(c); and

1200 (ii) expediting the process for renewal of a license under the requirements of this
1201 section and other applicable sections.

1202 (13) An individual or a department contractor who provides services in an adults only
1203 substance use disorder program, as defined by rule, is exempt from this section. This
1204 exemption does not extend to a program director or a member, as defined by Section
1205 [62A-2-108](#), of the program.

1206 (14) (a) Except as provided in Subsection (14)(b), in addition to the other requirements
1207 of this section, if the background check of an applicant is being conducted for the purpose of
1208 ~~[licensing a]~~ giving clearance status to an applicant seeking a position in a congregate care
1209 facility, an applicant for a one-time adoption, an applicant seeking to provide a prospective
1210 foster home ~~[or approving]~~, or an applicant seeking to provide a prospective adoptive
1211 [placement of a child in state custody] home, the office shall:

1212 (i) check the child abuse and neglect registry in each state where each applicant resided
1213 in the five years immediately preceding the day on which the applicant applied to be a foster
1214 parent or adoptive parent, to determine whether the prospective foster parent or prospective
1215 adoptive parent is listed in the registry as having a substantiated or supported finding of child
1216 abuse or neglect; and

1217 (ii) check the child abuse and neglect registry in each state where each adult living in
1218 the home of the applicant described in Subsection (14)(a)(i) resided in the five years
1219 immediately preceding the day on which the applicant applied to be a foster parent or adoptive
1220 parent, to determine whether the adult is listed in the registry as having a substantiated or
1221 supported finding of child abuse or neglect.

1222 (b) The requirements described in Subsection (14)(a) do not apply to the extent that:

1223 (i) federal law or rule permits otherwise; or

1224 (ii) the requirements would prohibit the Division of Child and Family Services or a
1225 court from placing a child with:

1226 (A) a noncustodial parent under Section [62A-4a-209](#), [78A-6-307](#), or [78A-6-307.5](#); or

1227 (B) a relative, other than a noncustodial parent, under Section [62A-4a-209](#), [78A-6-307](#),
1228 or [78A-6-307.5](#), pending completion of the background check described in Subsection (5).

1229 (c) Notwithstanding Subsections (5) through (9), the office shall deny a ~~[license or a~~
1230 license renewal to a] clearance to an applicant seeking a position in a program serving youth,
1231 an applicant for a one-time adoption, an applicant to become a prospective foster parent ~~[or a]~~,
1232 or an applicant to become a prospective adoptive parent if the applicant has been convicted of:

1233 (i) a felony involving conduct that constitutes any of the following:

1234 (A) child abuse, as described in Section [76-5-109](#);

1235 (B) commission of domestic violence in the presence of a child, as described in Section
1236 [76-5-109.1](#);

- 1237 (C) abuse or neglect of a child with a disability, as described in Section 76-5-110;
- 1238 (D) endangerment of a child or vulnerable adult, as described in Section 76-5-112.5;
- 1239 (E) aggravated murder, as described in Section 76-5-202;
- 1240 (F) murder, as described in Section 76-5-203;
- 1241 (G) manslaughter, as described in Section 76-5-205;
- 1242 (H) child abuse homicide, as described in Section 76-5-208;
- 1243 (I) homicide by assault, as described in Section 76-5-209;
- 1244 (J) kidnapping, as described in Section 76-5-301;
- 1245 (K) child kidnapping, as described in Section 76-5-301.1;
- 1246 (L) aggravated kidnapping, as described in Section 76-5-302;
- 1247 (M) human trafficking of a child, as described in Section 76-5-308.5;
- 1248 (N) an offense described in Title 76, Chapter 5, Part 4, Sexual Offenses;
- 1249 (O) sexual exploitation of a minor, as described in Section 76-5b-201;
- 1250 (P) aggravated arson, as described in Section 76-6-103;
- 1251 (Q) aggravated burglary, as described in Section 76-6-203;
- 1252 (R) aggravated robbery, as described in Section 76-6-302; or
- 1253 (S) domestic violence, as described in Section 77-36-1; or
- 1254 (ii) an offense committed outside the state that, if committed in the state, would
- 1255 constitute a violation of an offense described in Subsection (14)(c)(i).
- 1256 (d) Notwithstanding Subsections (5) through (9), the office shall deny a license or
- 1257 license renewal to a prospective foster parent or a prospective adoptive parent if, within the
- 1258 five years immediately preceding the day on which the individual's application or license would
- 1259 otherwise be approved, the applicant was convicted of a felony involving conduct that
- 1260 constitutes a violation of any of the following:
- 1261 (i) aggravated assault, as described in Section 76-5-103;
- 1262 (ii) aggravated assault by a prisoner, as described in Section 76-5-103.5;
- 1263 (iii) mayhem, as described in Section 76-5-105;
- 1264 (iv) an offense described in Title 58, Chapter 37, Utah Controlled Substances Act;
- 1265 (v) an offense described in Title 58, Chapter 37a, Utah Drug Paraphernalia Act;
- 1266 (vi) an offense described in Title 58, Chapter 37b, Imitation Controlled Substances
- 1267 Act;

1268 (vii) an offense described in Title 58, Chapter 37c, Utah Controlled Substance
1269 Precursor Act; or
1270 (viii) an offense described in Title 58, Chapter 37d, Clandestine Drug Lab Act.
1271 (e) In addition to the circumstances described in Subsection (6)(a), the office shall
1272 conduct the comprehensive review of an applicant's background check pursuant to this section
1273 if the registry check described in Subsection (14)(a) indicates that the individual is listed in a
1274 child abuse and neglect registry of another state as having a substantiated or supported finding
1275 of a severe type of child abuse or neglect as defined in Section [62A-4a-1002](#).

1276 Section 17. Section **62A-15-629** is amended to read:

1277 **62A-15-629. Temporary commitment -- Requirements and procedures.**

1278 (1) An adult shall be temporarily, involuntarily committed to a local mental health
1279 authority upon:

1280 (a) a written application that:

1281 (i) is completed by a responsible individual who has reason to know, stating a belief
1282 that the adult, due to mental illness, is likely to pose substantial danger to self or others if not
1283 restrained and stating the personal knowledge of the adult's condition or circumstances that
1284 lead to the individual's belief; and

1285 (ii) includes a certification by a licensed physician or designated examiner stating that
1286 the physician or designated examiner has examined the adult within a three-day period
1287 immediately preceding that certification, and that the physician or designated examiner is of the
1288 opinion that, due to mental illness, the adult poses a substantial danger to self or others; or

1289 (b) a peace officer or a mental health officer:

1290 (i) observing an adult's conduct that gives the peace officer or mental health officer
1291 probable cause to believe that:

1292 (A) the adult has a mental illness; and

1293 (B) because of the adult's mental illness and conduct, the adult poses a substantial
1294 danger to self or others; and

1295 (ii) completing a temporary commitment application that:

1296 (A) is on a form prescribed by the division;

1297 (B) states the peace officer's or mental health officer's belief that the adult poses a
1298 substantial danger to self or others;

- 1299 (C) states the specific nature of the danger;
- 1300 (D) provides a summary of the observations upon which the statement of danger is
1301 based; and
- 1302 (E) provides a statement of the facts that called the adult to the peace officer's or
1303 mental health officer's attention.
- 1304 (2) If at any time a patient committed under this section no longer meets the
1305 commitment criteria described in Subsection (1), the local mental health authority or the local
1306 mental health authority's designee shall document the change and release the patient.
- 1307 (3) A patient committed under this section may be held for a maximum of 24 hours
1308 after commitment, excluding Saturdays, Sundays, and legal holidays, unless:
- 1309 (a) as described in Section 62A-15-631, an application for involuntary commitment is
1310 commenced, which may be accompanied by an order of detention described in Subsection
1311 62A-15-631(4); or
- 1312 (b) the patient makes a voluntary application for admission.
- 1313 (4) Upon a written application described in Subsection (1)(a) or the observation and
1314 belief described in Subsection (1)(b)(i), the adult shall be:
- 1315 (a) taken into a peace officer's protective custody, by reasonable means, if necessary for
1316 public safety; and
- 1317 (b) transported for temporary commitment to a facility designated by the local mental
1318 health authority, by means of:
- 1319 (i) an ambulance, if the adult meets any of the criteria described in Section 26-8a-305;
1320 (ii) an ambulance, if a peace officer is not necessary for public safety, and
1321 transportation arrangements are made by a physician, designated examiner, or mental health
1322 officer;
- 1323 (iii) the city, town, or municipal law enforcement authority with jurisdiction over the
1324 location where the individual to be committed is present, if the individual is not transported by
1325 ambulance; ~~or~~
- 1326 (iv) the county sheriff, if the designated facility is outside of the jurisdiction of the law
1327 enforcement authority described in Subsection (4)(b)(iii) and the individual is not transported
1328 by ambulance~~[-];~~ or
- 1329 (v) nonemergency secured behavioral health transport as that term is defined in Section

1330 [26-8a-102.](#)

1331 (5) Notwithstanding Subsection (4):

1332 (a) an individual shall be transported by ambulance to an appropriate medical facility
1333 for treatment if the individual requires physical medical attention;

1334 (b) if an officer has probable cause to believe, based on the officer's experience and
1335 de-escalation training that taking an individual into protective custody or transporting an
1336 individual for temporary commitment would increase the risk of substantial danger to the
1337 individual or others, a peace officer may exercise discretion to not take the individual into
1338 custody or transport the individual, as permitted by policies and procedures established by the
1339 officer's law enforcement agency and any applicable federal or state statute, or case law; and

1340 (c) if an officer exercises discretion under Subsection (4)(b) to not take an individual
1341 into protective custody or transport an individual, the officer shall document in the officer's
1342 report the details and circumstances that led to the officer's decision.

1343 (6) Title 63G, Chapter 7, Governmental Immunity Act of Utah, applies to this section.
1344 This section does not create a special duty of care.

1345 Section 18. **Repealer.**

1346 This bill repeals:

1347 Section [26-18-404](#), **Home and community-based long-term care -- Room and board**
1348 **assistance.**

1349 Section [26-40-116](#), **Program to encourage appropriate emergency room use --**
1350 **Application for waivers.**