

1 **HEALTH AND HUMAN SERVICES RECODIFICATION -**
2 **HEALTH CARE ASSISTANCE AND DATA**

3 2023 GENERAL SESSION

4 STATE OF UTAH

5 **Chief Sponsor: Jacob L. Anderegg**

6 House Sponsor: Raymond P. Ward

8 **LONG TITLE**

9 **General Description:**

10 This bill recodifies portions of the Utah Health Code and Utah Human Services Code.

11 **Highlighted Provisions:**

12 This bill:

- 13 ▶ recodifies provisions regarding:
 - 14 • health care administration and assistance; and
 - 15 • vital statistics, health data, and the Utah Medical Examiner; and
- 16 ▶ makes technical and corresponding changes.

17 **Money Appropriated in this Bill:**

18 None

19 **Other Special Clauses:**

20 This bill provides a coordination clause.

21 This bill provides revisor instructions.

22 **Utah Code Sections Affected:**

23 AMENDS:

24 **26B-3-101**, as enacted by Laws of Utah 2022, Chapter 255

25 **26B-8-101**, as enacted by Laws of Utah 2022, Chapter 255

26 RENUMBERS AND AMENDS:

27 **26B-3-102**, (Renumbered from 26-18-2.1, as last amended by Laws of Utah 2019,
28 Chapter 393)

S.B. 39

Enrolled Copy

- 29 **26B-3-103**, (Renumbered from 26-18-2.2, as last amended by Laws of Utah 2019,
30 Chapter 393)
- 31 **26B-3-104**, (Renumbered from 26-18-2.3, as last amended by Laws of Utah 2020,
32 Chapter 225)
- 33 **26B-3-105**, (Renumbered from 26-18-2.4, as last amended by Laws of Utah 2022,
34 Chapter 255)
- 35 **26B-3-106**, (Renumbered from 26-18-2.5, as last amended by Laws of Utah 2019,
36 Chapter 393)
- 37 **26B-3-107**, (Renumbered from 26-18-2.6, as last amended by Laws of Utah 2021,
38 Chapter 234)
- 39 **26B-3-108**, (Renumbered from 26-18-3, as last amended by Laws of Utah 2021,
40 Chapter 422)
- 41 **26B-3-109**, (Renumbered from 26-18-3.1, as last amended by Laws of Utah 2020,
42 Chapter 225)
- 43 **26B-3-110**, (Renumbered from 26-18-3.5, as last amended by Laws of Utah 2019,
44 Chapter 393)
- 45 **26B-3-111**, (Renumbered from 26-18-3.6, as last amended by Laws of Utah 2019,
46 Chapter 393)
- 47 **26B-3-112**, (Renumbered from 26-18-3.8, as last amended by Laws of Utah 2020, Sixth
48 Special Session, Chapter 3)
- 49 **26B-3-113**, (Renumbered from 26-18-3.9, as last amended by Laws of Utah 2020, Fifth
50 Special Session, Chapter 4)
- 51 **26B-3-114**, (Renumbered from 26-18-4, as last amended by Laws of Utah 2013,
52 Chapter 167)
- 53 **26B-3-115**, (Renumbered from 26-18-5, as last amended by Laws of Utah 2020,
54 Chapter 225)
- 55 **26B-3-116**, (Renumbered from 26-18-5.5, as enacted by Laws of Utah 2022, Chapter

56 469)
57 **26B-3-117**, (Renumbered from 26-18-6, as enacted by Laws of Utah 1981, Chapter
58 126)
59 **26B-3-118**, (Renumbered from 26-18-7, as last amended by Laws of Utah 1988,
60 Chapter 21)
61 **26B-3-119**, (Renumbered from 26-18-8, as last amended by Laws of Utah 2020,
62 Chapter 225)
63 **26B-3-120**, (Renumbered from 26-18-9, as enacted by Laws of Utah 1981, Chapter
64 126)
65 **26B-3-121**, (Renumbered from 26-18-11, as last amended by Laws of Utah 2019,
66 Chapter 393)
67 **26B-3-122**, (Renumbered from 26-18-13, as last amended by Laws of Utah 2017,
68 Chapter 241)
69 **26B-3-123**, (Renumbered from 26-18-13.5, as last amended by Laws of Utah 2019,
70 Chapter 249)
71 **26B-3-124**, (Renumbered from 26-18-15, as last amended by Laws of Utah 2021,
72 Chapter 163)
73 **26B-3-125**, (Renumbered from 26-18-16, as enacted by Laws of Utah 2012, Chapter
74 155)
75 **26B-3-126**, (Renumbered from 26-18-17, as enacted by Laws of Utah 2013, Chapter
76 53)
77 **26B-3-127**, (Renumbered from 26-18-18, as last amended by Laws of Utah 2019,
78 Chapter 393)
79 **26B-3-128**, (Renumbered from 26-18-19, as last amended by Laws of Utah 2016,
80 Chapter 114)
81 **26B-3-129**, (Renumbered from 26-18-20, as last amended by Laws of Utah 2022,
82 Chapter 443)

- 83 **26B-3-130**, (Renumbered from 26-18-21, as last amended by Laws of Utah 2019,
84 Chapter 393)
- 85 **26B-3-131**, (Renumbered from 26-18-22, as enacted by Laws of Utah 2017, Chapter
86 180)
- 87 **26B-3-132**, (Renumbered from 26-18-23, as enacted by Laws of Utah 2017, Chapter
88 53)
- 89 **26B-3-133**, (Renumbered from 26-18-24, as enacted by Laws of Utah 2018, Chapter
90 180)
- 91 **26B-3-134**, (Renumbered from 26-18-25, as enacted by Laws of Utah 2019, Chapter
92 320)
- 93 **26B-3-135**, (Renumbered from 26-18-26, as enacted by Laws of Utah 2019, Chapter
94 265)
- 95 **26B-3-136**, (Renumbered from 26-18-27, as enacted by Laws of Utah 2021, Chapter
96 163)
- 97 **26B-3-137**, (Renumbered from 26-18-28, as enacted by Laws of Utah 2022, Chapter
98 206)
- 99 **26B-3-138**, (Renumbered from 26-18-427, as enacted by Laws of Utah 2022, Chapter
100 394)
- 101 **26B-3-139**, (Renumbered from 26-18-603, as last amended by Laws of Utah 2015,
102 Chapter 135)
- 103 **26B-3-140**, (Renumbered from 26-18-604, as last amended by Laws of Utah 2015,
104 Chapter 135)
- 105 **26B-3-141**, (Renumbered from 26-18-703, as renumbered and amended by Laws of
106 Utah 2022, Chapter 334)
- 107 **26B-3-201**, (Renumbered from 26-18-403, as enacted by Laws of Utah 2006, Chapter
108 110)
- 109 **26B-3-202**, (Renumbered from 26-18-405, as last amended by Laws of Utah 2020,

110 Chapter 275)
111 **26B-3-203**, (Renumbered from 26-18-405.5, as last amended by Laws of Utah 2022,
112 Chapter 149)
113 **26B-3-204**, (Renumbered from 26-18-408, as last amended by Laws of Utah 2020,
114 Fifth Special Session, Chapter 4)
115 **26B-3-205**, (Renumbered from 26-18-409, as enacted by Laws of Utah 2014, Chapter
116 174)
117 **26B-3-206**, (Renumbered from 26-18-410, as last amended by Laws of Utah 2022,
118 Chapter 226)
119 **26B-3-207**, (Renumbered from 26-18-411, as last amended by Laws of Utah 2022,
120 Chapter 394)
121 **26B-3-208**, (Renumbered from 26-18-413, as last amended by Laws of Utah 2020,
122 Chapter 225)
123 **26B-3-209**, (Renumbered from 26-18-414, as enacted by Laws of Utah 2017, Chapter
124 307)
125 **26B-3-210**, (Renumbered from 26-18-415, as last amended by Laws of Utah 2019,
126 Chapters 1 and 393)
127 **26B-3-211**, (Renumbered from 26-18-416, as last amended by Laws of Utah 2020,
128 Chapter 354)
129 **26B-3-212**, (Renumbered from 26-18-417, as last amended by Laws of Utah 2019,
130 Chapter 393)
131 **26B-3-213**, (Renumbered from 26-18-418, as last amended by Laws of Utah 2020,
132 Chapter 303)
133 **26B-3-214**, (Renumbered from 26-18-419, as enacted by Laws of Utah 2019, Chapter
134 172)
135 **26B-3-215**, (Renumbered from 26-18-420, as enacted by Laws of Utah 2020, Chapter
136 187)

- 137 **26B-3-216**, (Renumbered from 26-18-420.1, as enacted by Laws of Utah 2021, Chapter
138 133)
- 139 **26B-3-217**, (Renumbered from 26-18-421, as enacted by Laws of Utah 2020, Chapter
140 159)
- 141 **26B-3-218**, (Renumbered from 26-18-422, as enacted by Laws of Utah 2020, Chapter
142 188)
- 143 **26B-3-219**, (Renumbered from 26-18-423, as enacted by Laws of Utah 2020, Chapter
144 303)
- 145 **26B-3-220**, (Renumbered from 26-18-424, as enacted by Laws of Utah 2021, Chapter
146 76)
- 147 **26B-3-221**, (Renumbered from 26-18-425, as enacted by Laws of Utah 2021, Chapter
148 27)
- 149 **26B-3-222**, (Renumbered from 26-18-426, as enacted by Laws of Utah 2021, Chapter
150 212)
- 151 **26B-3-223**, (Renumbered from 26-18-428, as enacted by Laws of Utah 2022, Chapter
152 394)
- 153 **26B-3-224**, (Renumbered from 26-18-429, as enacted by Laws of Utah 2022, Chapter
154 253)
- 155 **26B-3-301**, (Renumbered from 26-18-101, as last amended by Laws of Utah 2004,
156 Chapter 280)
- 157 **26B-3-302**, (Renumbered from 26-18-102, as last amended by Laws of Utah 2010,
158 Chapters 286 and 324)
- 159 **26B-3-303**, (Renumbered from 26-18-103, as last amended by Laws of Utah 2020,
160 Chapter 225)
- 161 **26B-3-304**, (Renumbered from 26-18-104, as last amended by Laws of Utah 2008,
162 Chapter 382)
- 163 **26B-3-305**, (Renumbered from 26-18-105, as last amended by Laws of Utah 2010,

164 Chapter 205)
165 **26B-3-306**, (Renumbered from 26-18-106, as enacted by Laws of Utah 1992, Chapter
166 273)
167 **26B-3-307**, (Renumbered from 26-18-107, as last amended by Laws of Utah 2019,
168 Chapter 349)
169 **26B-3-308**, (Renumbered from 26-18-108, as enacted by Laws of Utah 1992, Chapter
170 273)
171 **26B-3-309**, (Renumbered from 26-18-109, as enacted by Laws of Utah 1992, Chapter
172 273)
173 **26B-3-310**, (Renumbered from 26-18-502, as last amended by Laws of Utah 2021,
174 Chapter 274)
175 **26B-3-311**, (Renumbered from 26-18-503, as last amended by Laws of Utah 2022,
176 Chapter 274)
177 **26B-3-312**, (Renumbered from 26-18-504, as last amended by Laws of Utah 2017,
178 Chapter 443)
179 **26B-3-313**, (Renumbered from 26-18-505, as last amended by Laws of Utah 2017,
180 Chapter 443)
181 **26B-3-401**, (Renumbered from 26-35a-103, as last amended by Laws of Utah 2018,
182 Chapter 39)
183 **26B-3-402**, (Renumbered from 26-35a-102, as last amended by Laws of Utah 2011,
184 Chapter 366)
185 **26B-3-403**, (Renumbered from 26-35a-104, as last amended by Laws of Utah 2017,
186 Chapter 443)
187 **26B-3-404**, (Renumbered from 26-35a-105, as enacted by Laws of Utah 2004, Chapter
188 284)
189 **26B-3-405**, (Renumbered from 26-35a-107, as last amended by Laws of Utah 2017,
190 Chapter 443)

- 191 **26B-3-406**, (Renumbered from 26-35a-108, as last amended by Laws of Utah 2011,
192 Chapter 366)
- 193 **26B-3-501**, (Renumbered from 26-36b-103, as last amended by Laws of Utah 2019,
194 Chapter 1)
- 195 **26B-3-502**, (Renumbered from 26-36b-102, as last amended by Laws of Utah 2018,
196 Chapter 384)
- 197 **26B-3-503**, (Renumbered from 26-36b-201, as last amended by Laws of Utah 2018,
198 Chapters 384 and 468)
- 199 **26B-3-504**, (Renumbered from 26-36b-202, as last amended by Laws of Utah 2019,
200 Chapter 393)
- 201 **26B-3-505**, (Renumbered from 26-36b-203, as last amended by Laws of Utah 2018,
202 Chapters 384 and 468)
- 203 **26B-3-506**, (Renumbered from 26-36b-204, as last amended by Laws of Utah 2020,
204 Chapter 225)
- 205 **26B-3-507**, (Renumbered from 26-36b-205, as last amended by Laws of Utah 2020,
206 Chapter 225)
- 207 **26B-3-508**, (Renumbered from 26-36b-206, as last amended by Laws of Utah 2018,
208 Chapters 384 and 468)
- 209 **26B-3-509**, (Renumbered from 26-36b-207, as last amended by Laws of Utah 2018,
210 Chapters 384 and 468)
- 211 **26B-3-510**, (Renumbered from 26-36b-209, as last amended by Laws of Utah 2018,
212 Chapters 384 and 468)
- 213 **26B-3-511**, (Renumbered from 26-36b-210, as last amended by Laws of Utah 2018,
214 Chapters 384 and 468)
- 215 **26B-3-512**, (Renumbered from 26-36b-211, as last amended by Laws of Utah 2018,
216 Chapters 384 and 468)
- 217 **26B-3-601**, (Renumbered from 26-36c-102, as last amended by Laws of Utah 2019,

218 Chapter 1)
219 **26B-3-602**, (Renumbered from 26-36c-103, as enacted by Laws of Utah 2018, Chapter
220 468)
221 **26B-3-603**, (Renumbered from 26-36c-201, as last amended by Laws of Utah 2019,
222 Chapter 1)
223 **26B-3-604**, (Renumbered from 26-36c-202, as last amended by Laws of Utah 2019,
224 Chapter 393)
225 **26B-3-605**, (Renumbered from 26-36c-203, as last amended by Laws of Utah 2019,
226 Chapter 1)
227 **26B-3-606**, (Renumbered from 26-36c-204, as last amended by Laws of Utah 2020,
228 Chapter 225)
229 **26B-3-607**, (Renumbered from 26-36c-205, as last amended by Laws of Utah 2019,
230 Chapter 136)
231 **26B-3-608**, (Renumbered from 26-36c-206, as last amended by Laws of Utah 2019,
232 Chapter 1)
233 **26B-3-609**, (Renumbered from 26-36c-207, as enacted by Laws of Utah 2018, Chapter
234 468)
235 **26B-3-610**, (Renumbered from 26-36c-208, as last amended by Laws of Utah 2019,
236 Chapter 1)
237 **26B-3-611**, (Renumbered from 26-36c-209, as last amended by Laws of Utah 2019,
238 Chapter 1)
239 **26B-3-612**, (Renumbered from 26-36c-210, as last amended by Laws of Utah 2019,
240 Chapter 136)
241 **26B-3-701**, (Renumbered from 26-36d-103, as repealed and reenacted by Laws of Utah
242 2019, Chapter 455)
243 **26B-3-702**, (Renumbered from 26-36d-102, as repealed and reenacted by Laws of Utah
244 2019, Chapter 455)

- 245 **26B-3-703**, (Renumbered from 26-36d-201, as repealed and reenacted by Laws of Utah
246 2019, Chapter 455)
- 247 **26B-3-704**, (Renumbered from 26-36d-202, as repealed and reenacted by Laws of Utah
248 2019, Chapter 455)
- 249 **26B-3-705**, (Renumbered from 26-36d-203, as repealed and reenacted by Laws of Utah
250 2019, Chapter 455)
- 251 **26B-3-706**, (Renumbered from 26-36d-204, as repealed and reenacted by Laws of Utah
252 2019, Chapter 455)
- 253 **26B-3-707**, (Renumbered from 26-36d-205, as repealed and reenacted by Laws of Utah
254 2019, Chapter 455)
- 255 **26B-3-708**, (Renumbered from 26-36d-206, as repealed and reenacted by Laws of Utah
256 2019, Chapter 455)
- 257 **26B-3-709**, (Renumbered from 26-36d-208, as repealed and reenacted by Laws of Utah
258 2019, Chapter 455)
- 259 **26B-3-801**, (Renumbered from 26-37a-102, as last amended by Laws of Utah 2016,
260 Chapter 348)
- 261 **26B-3-802**, (Renumbered from 26-37a-103, as enacted by Laws of Utah 2015, Chapter
262 440)
- 263 **26B-3-803**, (Renumbered from 26-37a-104, as enacted by Laws of Utah 2015, Chapter
264 440)
- 265 **26B-3-804**, (Renumbered from 26-37a-105, as enacted by Laws of Utah 2015, Chapter
266 440)
- 267 **26B-3-805**, (Renumbered from 26-37a-106, as enacted by Laws of Utah 2015, Chapter
268 440)
- 269 **26B-3-806**, (Renumbered from 26-37a-108, as enacted by Laws of Utah 2015, Chapter
270 440)
- 271 **26B-3-901**, (Renumbered from 26-40-102, as last amended by Laws of Utah 2019,

272 Chapter 393)
273 **26B-3-902**, (Renumbered from 26-40-103, as last amended by Laws of Utah 2019,
274 Chapter 393)
275 **26B-3-903**, (Renumbered from 26-40-105, as last amended by Laws of Utah 2019,
276 Chapter 393)
277 **26B-3-904**, (Renumbered from 26-40-106, as last amended by Laws of Utah 2021,
278 Chapter 175)
279 **26B-3-905**, (Renumbered from 26-40-107, as enacted by Laws of Utah 1998, Chapter
280 360)
281 **26B-3-906**, (Renumbered from 26-40-108, as last amended by Laws of Utah 2010,
282 Chapter 391)
283 **26B-3-907**, (Renumbered from 26-40-109, as last amended by Laws of Utah 2013,
284 Chapter 167)
285 **26B-3-908**, (Renumbered from 26-40-110, as last amended by Laws of Utah 2019,
286 Chapter 393)
287 **26B-3-909**, (Renumbered from 26-40-115, as last amended by Laws of Utah 2020,
288 Chapters 32 and 152)
289 **26B-3-1001**, (Renumbered from 26-19-102, as renumbered and amended by Laws of
290 Utah 2018, Chapter 443)
291 **26B-3-1002**, (Renumbered from 26-19-103, as renumbered and amended by Laws of
292 Utah 2018, Chapter 443)
293 **26B-3-1003**, (Renumbered from 26-19-201, as last amended by Laws of Utah 2021,
294 Chapter 300)
295 **26B-3-1004**, (Renumbered from 26-19-301, as renumbered and amended by Laws of
296 Utah 2018, Chapter 443)
297 **26B-3-1005**, (Renumbered from 26-19-302, as last amended by Laws of Utah 2020,
298 Chapter 354)

- 299 **26B-3-1006**, (Renumbered from 26-19-303, as renumbered and amended by Laws of
300 Utah 2018, Chapter 443)
- 301 **26B-3-1007**, (Renumbered from 26-19-304, as renumbered and amended by Laws of
302 Utah 2018, Chapter 443)
- 303 **26B-3-1008**, (Renumbered from 26-19-305, as renumbered and amended by Laws of
304 Utah 2018, Chapter 443)
- 305 **26B-3-1009**, (Renumbered from 26-19-401, as last amended by Laws of Utah 2021,
306 Chapter 300)
- 307 **26B-3-1010**, (Renumbered from 26-19-402, as renumbered and amended by Laws of
308 Utah 2018, Chapter 443)
- 309 **26B-3-1011**, (Renumbered from 26-19-403, as renumbered and amended by Laws of
310 Utah 2018, Chapter 443)
- 311 **26B-3-1012**, (Renumbered from 26-19-404, as enacted by Laws of Utah 2018, Chapter
312 443)
- 313 **26B-3-1013**, (Renumbered from 26-19-405, as renumbered and amended by Laws of
314 Utah 2018, Chapter 443)
- 315 **26B-3-1014**, (Renumbered from 26-19-406, as renumbered and amended by Laws of
316 Utah 2018, Chapter 443)
- 317 **26B-3-1015**, (Renumbered from 26-19-501, as enacted by Laws of Utah 2018, Chapter
318 443)
- 319 **26B-3-1016**, (Renumbered from 26-19-502, as enacted by Laws of Utah 2018, Chapter
320 443)
- 321 **26B-3-1017**, (Renumbered from 26-19-503, as enacted by Laws of Utah 2018, Chapter
322 443)
- 323 **26B-3-1018**, (Renumbered from 26-19-504, as enacted by Laws of Utah 2018, Chapter
324 443)
- 325 **26B-3-1019**, (Renumbered from 26-19-505, as enacted by Laws of Utah 2018, Chapter

326 443)
327 **26B-3-1020**, (Renumbered from 26-19-506, as enacted by Laws of Utah 2018, Chapter
328 443)
329 **26B-3-1021**, (Renumbered from 26-19-507, as enacted by Laws of Utah 2018, Chapter
330 443)
331 **26B-3-1022**, (Renumbered from 26-19-508, as enacted by Laws of Utah 2018, Chapter
332 443)
333 **26B-3-1023**, (Renumbered from 26-19-509, as enacted by Laws of Utah 2018, Chapter
334 443)
335 **26B-3-1024**, (Renumbered from 26-19-601, as renumbered and amended by Laws of
336 Utah 2018, Chapter 443)
337 **26B-3-1025**, (Renumbered from 26-19-602, as renumbered and amended by Laws of
338 Utah 2018, Chapter 443)
339 **26B-3-1026**, (Renumbered from 26-19-603, as renumbered and amended by Laws of
340 Utah 2018, Chapter 443)
341 **26B-3-1027**, (Renumbered from 26-19-604, as renumbered and amended by Laws of
342 Utah 2018, Chapter 443)
343 **26B-3-1028**, (Renumbered from 26-19-605, as renumbered and amended by Laws of
344 Utah 2018, Chapter 443)
345 **26B-3-1101**, (Renumbered from 26-20-2, as last amended by Laws of Utah 2007,
346 Chapter 48)
347 **26B-3-1102**, (Renumbered from 26-20-3, as last amended by Laws of Utah 2011,
348 Chapter 297)
349 **26B-3-1103**, (Renumbered from 26-20-4, as repealed and reenacted by Laws of Utah
350 2007, Chapter 48)
351 **26B-3-1104**, (Renumbered from 26-20-5, as last amended by Laws of Utah 2007,
352 Chapter 48)

353 **26B-3-1105**, (Renumbered from 26-20-6, as last amended by Laws of Utah 2011,
354 Chapter 297)
355 **26B-3-1106**, (Renumbered from 26-20-7, as last amended by Laws of Utah 2007,
356 Chapter 48)
357 **26B-3-1107**, (Renumbered from 26-20-8, as last amended by Laws of Utah 2011,
358 Chapter 297)
359 **26B-3-1108**, (Renumbered from 26-20-9, as last amended by Laws of Utah 2007,
360 Chapter 48)
361 **26B-3-1109**, (Renumbered from 26-20-9.5, as last amended by Laws of Utah 2011,
362 Chapter 297)
363 **26B-3-1110**, (Renumbered from 26-20-10, as last amended by Laws of Utah 1998,
364 Chapter 192)
365 **26B-3-1111**, (Renumbered from 26-20-11, as enacted by Laws of Utah 1986, Chapter
366 46)
367 **26B-3-1112**, (Renumbered from 26-20-12, as last amended by Laws of Utah 2011,
368 Chapter 297)
369 **26B-3-1113**, (Renumbered from 26-20-13, as last amended by Laws of Utah 2007,
370 Chapter 48)
371 **26B-3-1114**, (Renumbered from 26-20-14, as last amended by Laws of Utah 2011,
372 Chapter 297)
373 **26B-3-1115**, (Renumbered from 26-20-15, as enacted by Laws of Utah 2007, Chapter
374 48)
375 **26B-8-102**, (Renumbered from 26-2-3, as last amended by Laws of Utah 2017, Chapter
376 22)
377 **26B-8-103**, (Renumbered from 26-2-4, as last amended by Laws of Utah 2022,
378 Chapters 231 and 365)
379 **26B-8-104**, (Renumbered from 26-2-5, as last amended by Laws of Utah 2019, Chapter

380 349)
381 **26B-8-105**, (Renumbered from 26-2-5.5, as last amended by Laws of Utah 1995,
382 Chapter 202)
383 **26B-8-106**, (Renumbered from 26-2-6, as last amended by Laws of Utah 1995, Chapter
384 202)
385 **26B-8-107**, (Renumbered from 26-2-7, as last amended by Laws of Utah 2022, Chapter
386 231)
387 **26B-8-108**, (Renumbered from 26-2-8, as last amended by Laws of Utah 1995, Chapter
388 202)
389 **26B-8-109**, (Renumbered from 26-2-9, as last amended by Laws of Utah 1995, Chapter
390 202)
391 **26B-8-110**, (Renumbered from 26-2-10, as last amended by Laws of Utah 2021,
392 Chapter 65)
393 **26B-8-111**, (Renumbered from 26-2-11, as last amended by Laws of Utah 1995,
394 Chapter 202)
395 **26B-8-112**, (Renumbered from 26-2-12.5, as last amended by Laws of Utah 2022,
396 Chapters 255 and 335)
397 **26B-8-113**, (Renumbered from 26-2-12.6, as last amended by Laws of Utah 2022,
398 Chapters 255 and 365)
399 **26B-8-114**, (Renumbered from 26-2-13, as last amended by Laws of Utah 2021,
400 Chapters 11 and 297)
401 **26B-8-115**, (Renumbered from 26-2-14, as last amended by Laws of Utah 1995,
402 Chapter 202)
403 **26B-8-116**, (Renumbered from 26-2-14.1, as enacted by Laws of Utah 2002, Chapter
404 69)
405 **26B-8-117**, (Renumbered from 26-2-14.2, as enacted by Laws of Utah 2002, Chapter
406 69)

407 **26B-8-118**, (Renumbered from 26-2-14.3, as enacted by Laws of Utah 2015, Chapter
408 184)
409 **26B-8-119**, (Renumbered from 26-2-15, as last amended by Laws of Utah 2020,
410 Chapter 201)
411 **26B-8-120**, (Renumbered from 26-2-16, as last amended by Laws of Utah 2009,
412 Chapters 66 and 68)
413 **26B-8-121**, (Renumbered from 26-2-17, as last amended by Laws of Utah 2020,
414 Chapter 251)
415 **26B-8-122**, (Renumbered from 26-2-18, as last amended by Laws of Utah 2020,
416 Chapter 251)
417 **26B-8-123**, (Renumbered from 26-2-19, as last amended by Laws of Utah 1995,
418 Chapter 202)
419 **26B-8-124**, (Renumbered from 26-2-21, as last amended by Laws of Utah 1995,
420 Chapter 202)
421 **26B-8-125**, (Renumbered from 26-2-22, as last amended by Laws of Utah 2021,
422 Chapter 262)
423 **26B-8-126**, (Renumbered from 26-2-23, as last amended by Laws of Utah 2009,
424 Chapter 68)
425 **26B-8-127**, (Renumbered from 26-2-24, as last amended by Laws of Utah 1995,
426 Chapter 202)
427 **26B-8-128**, (Renumbered from 26-2-25, as last amended by Laws of Utah 2021,
428 Chapter 65)
429 **26B-8-129**, (Renumbered from 26-2-26, as last amended by Laws of Utah 1995,
430 Chapter 202)
431 **26B-8-130**, (Renumbered from 26-2-27, as last amended by Laws of Utah 2011,
432 Chapter 366)
433 **26B-8-131**, (Renumbered from 26-2-28, as last amended by Laws of Utah 2021,

434 Chapter 65)
435 **26B-8-132**, (Renumbered from 26-34-4, as enacted by Laws of Utah 2020, Chapter
436 353)
437 **26B-8-133**, (Renumbered from 26-23-5, as last amended by Laws of Utah 1995,
438 Chapter 202)
439 **26B-8-134**, (Renumbered from 26-23-5.5, as enacted by Laws of Utah 1995, Chapter
440 202)
441 **26B-8-201**, (Renumbered from 26-4-2, as last amended by Laws of Utah 2022, Chapter
442 277)
443 **26B-8-202**, (Renumbered from 26-4-4, as last amended by Laws of Utah 2015, Chapter
444 72)
445 **26B-8-203**, (Renumbered from 26-4-5, as last amended by Laws of Utah 1993, Chapter
446 227)
447 **26B-8-204**, (Renumbered from 26-4-6, as last amended by Laws of Utah 2009, Chapter
448 63)
449 **26B-8-205**, (Renumbered from 26-4-7, as last amended by Laws of Utah 2021, Chapter
450 25)
451 **26B-8-206**, (Renumbered from 26-4-8, as last amended by Laws of Utah 1993, Chapter
452 38)
453 **26B-8-207**, (Renumbered from 26-4-9, as last amended by Laws of Utah 2021, Chapter
454 297)
455 **26B-8-208**, (Renumbered from 26-2-18.5, as last amended by Laws of Utah 2019,
456 Chapter 189)
457 **26B-8-209**, (Renumbered from 26-4-10, as last amended by Laws of Utah 2021,
458 Chapter 25)
459 **26B-8-210**, (Renumbered from 26-4-10.5, as last amended by Laws of Utah 2022,
460 Chapter 415)

461 **26B-8-211**, (Renumbered from 26-4-11, as last amended by Laws of Utah 2018,
462 Chapter 414)
463 **26B-8-212**, (Renumbered from 26-4-12, as last amended by Laws of Utah 2011,
464 Chapter 297)
465 **26B-8-213**, (Renumbered from 26-4-13, as last amended by Laws of Utah 2001,
466 Chapter 278)
467 **26B-8-214**, (Renumbered from 26-4-14, as last amended by Laws of Utah 2021,
468 Chapter 297)
469 **26B-8-215**, (Renumbered from 26-4-15, as enacted by Laws of Utah 1981, Chapter
470 126)
471 **26B-8-216**, (Renumbered from 26-4-16, as last amended by Laws of Utah 2007,
472 Chapter 144)
473 **26B-8-217**, (Renumbered from 26-4-17, as last amended by Laws of Utah 2022,
474 Chapter 255)
475 **26B-8-218**, (Renumbered from 26-4-18, as enacted by Laws of Utah 1981, Chapter
476 126)
477 **26B-8-219**, (Renumbered from 26-4-19, as last amended by Laws of Utah 1993,
478 Chapter 38)
479 **26B-8-220**, (Renumbered from 26-4-20, as last amended by Laws of Utah 2011,
480 Chapter 297)
481 **26B-8-221**, (Renumbered from 26-4-21, as last amended by Laws of Utah 1997,
482 Chapter 372)
483 **26B-8-222**, (Renumbered from 26-4-22, as enacted by Laws of Utah 1981, Chapter
484 126)
485 **26B-8-223**, (Renumbered from 26-4-23, as enacted by Laws of Utah 1981, Chapter
486 126)
487 **26B-8-224**, (Renumbered from 26-4-24, as last amended by Laws of Utah 1997,

488 Chapter 375)
489 **26B-8-225**, (Renumbered from 26-4-25, as repealed and reenacted by Laws of Utah
490 2015, Chapter 72)
491 **26B-8-226**, (Renumbered from 26-4-26, as enacted by Laws of Utah 1997, Chapter
492 232)
493 **26B-8-227**, (Renumbered from 26-4-27, as enacted by Laws of Utah 1998, Chapter
494 153)
495 **26B-8-228**, (Renumbered from 26-4-28, as last amended by Laws of Utah 2013,
496 Chapter 167)
497 **26B-8-229**, (Renumbered from 26-4-28.5, as enacted by Laws of Utah 2017, Chapter
498 346)
499 **26B-8-230**, (Renumbered from 26-4-29, as last amended by Laws of Utah 2010,
500 Chapter 218)
501 **26B-8-231**, (Renumbered from 26-4-30, as enacted by Laws of Utah 2020, Chapter
502 201)
503 **26B-8-232**, (Renumbered from 26-23a-2, as last amended by Laws of Utah 1996,
504 Chapter 23)
505 **26B-8-301**, (Renumbered from 26-28-102, as enacted by Laws of Utah 2007, Chapter
506 60)
507 **26B-8-302**, (Renumbered from 26-28-103, as enacted by Laws of Utah 2007, Chapter
508 60)
509 **26B-8-303**, (Renumbered from 26-28-104, as enacted by Laws of Utah 2007, Chapter
510 60)
511 **26B-8-304**, (Renumbered from 26-28-105, as last amended by Laws of Utah 2011,
512 Chapter 297)
513 **26B-8-305**, (Renumbered from 26-28-106, as last amended by Laws of Utah 2011,
514 Chapter 297)

- 515 **26B-8-306**, (Renumbered from 26-28-107, as last amended by Laws of Utah 2011,
516 Chapter 297)
- 517 **26B-8-307**, (Renumbered from 26-28-108, as enacted by Laws of Utah 2007, Chapter
518 60)
- 519 **26B-8-308**, (Renumbered from 26-28-109, as last amended by Laws of Utah 2018,
520 Chapter 48)
- 521 **26B-8-309**, (Renumbered from 26-28-110, as enacted by Laws of Utah 2007, Chapter
522 60)
- 523 **26B-8-310**, (Renumbered from 26-28-111, as last amended by Laws of Utah 2011,
524 Chapter 297)
- 525 **26B-8-311**, (Renumbered from 26-28-112, as last amended by Laws of Utah 2014,
526 Chapter 189)
- 527 **26B-8-312**, (Renumbered from 26-28-113, as enacted by Laws of Utah 2007, Chapter
528 60)
- 529 **26B-8-313**, (Renumbered from 26-28-114, as last amended by Laws of Utah 2019,
530 Chapter 349)
- 531 **26B-8-314**, (Renumbered from 26-28-115, as enacted by Laws of Utah 2007, Chapter
532 60)
- 533 **26B-8-315**, (Renumbered from 26-28-116, as enacted by Laws of Utah 2007, Chapter
534 60)
- 535 **26B-8-316**, (Renumbered from 26-28-117, as enacted by Laws of Utah 2007, Chapter
536 60)
- 537 **26B-8-317**, (Renumbered from 26-28-118, as last amended by Laws of Utah 2018,
538 Chapter 48)
- 539 **26B-8-318**, (Renumbered from 26-28-119, as enacted by Laws of Utah 2007, Chapter
540 60)
- 541 **26B-8-319**, (Renumbered from 26-28-120, as last amended by Laws of Utah 2011,

542 Chapter 297)
543 **26B-8-320**, (Renumbered from 26-28-121, as last amended by Laws of Utah 2011,
544 Chapter 297)
545 **26B-8-321**, (Renumbered from 26-28-122, as enacted by Laws of Utah 2007, Chapter
546 60)
547 **26B-8-322**, (Renumbered from 26-28-123, as enacted by Laws of Utah 2007, Chapter
548 60)
549 **26B-8-323**, (Renumbered from 26-28-124, as last amended by Laws of Utah 2011,
550 Chapter 297)
551 **26B-8-324**, (Renumbered from 26-28-125, as enacted by Laws of Utah 2007, Chapter
552 60)
553 **26B-8-401**, (Renumbered from 26-3-1, as last amended by Laws of Utah 1995, Chapter
554 202)
555 **26B-8-402**, (Renumbered from 26-3-2, as enacted by Laws of Utah 1981, Chapter 126)
556 **26B-8-403**, (Renumbered from 26-3-4, as enacted by Laws of Utah 1981, Chapter 126)
557 **26B-8-404**, (Renumbered from 26-3-5, as last amended by Laws of Utah 1996, Chapter
558 201)
559 **26B-8-405**, (Renumbered from 26-3-6, as last amended by Laws of Utah 1996, Chapter
560 201)
561 **26B-8-406**, (Renumbered from 26-3-7, as last amended by Laws of Utah 2013, Chapter
562 278)
563 **26B-8-407**, (Renumbered from 26-3-8, as last amended by Laws of Utah 2011, Chapter
564 297)
565 **26B-8-408**, (Renumbered from 26-3-9, as last amended by Laws of Utah 1996, Chapter
566 201)
567 **26B-8-409**, (Renumbered from 26-3-10, as last amended by Laws of Utah 1996,
568 Chapter 201)

569 **26B-8-410**, (Renumbered from 26-3-11, as last amended by Laws of Utah 2005,
570 Chapter 243)
571 **26B-8-411**, (Renumbered from 26-1-37, as last amended by Laws of Utah 2019,
572 Chapter 105)
573 **26B-8-501**, (Renumbered from 26-33a-102, as last amended by Laws of Utah 2022,
574 Chapter 255)
575 **26B-8-502**, (Renumbered from 26-33a-105, as enacted by Laws of Utah 1990, Chapter
576 305)
577 **26B-8-503**, (Renumbered from 26-33a-106, as last amended by Laws of Utah 1996,
578 Chapter 201)
579 **26B-8-504**, (Renumbered from 26-33a-106.1, as last amended by Laws of Utah 2022,
580 Chapter 321)
581 **26B-8-505**, (Renumbered from 26-33a-106.5, as last amended by Laws of Utah 2019,
582 Chapter 370)
583 **26B-8-506**, (Renumbered from 26-33a-107, as last amended by Laws of Utah 2016,
584 Chapter 74)
585 **26B-8-507**, (Renumbered from 26-33a-108, as last amended by Laws of Utah 1996,
586 Chapter 201)
587 **26B-8-508**, (Renumbered from 26-33a-109, as last amended by Laws of Utah 2021,
588 Chapter 277)
589 **26B-8-509**, (Renumbered from 26-33a-110, as enacted by Laws of Utah 1990, Chapter
590 305)
591 **26B-8-510**, (Renumbered from 26-33a-111, as last amended by Laws of Utah 2011,
592 Chapter 297)
593 **26B-8-511**, (Renumbered from 26-33a-115, as enacted by Laws of Utah 2013, Chapter
594 102)
595 **26B-8-512**, (Renumbered from 26-33a-116, as enacted by Laws of Utah 2019, Chapter

596 287)

597 **26B-8-513**, (Renumbered from 26-33a-117, as enacted by Laws of Utah 2020, Chapter

598 181)

599 **26B-8-514**, (Renumbered from 26-70-102, as enacted by Laws of Utah 2022, Chapter

600 327)

601 **Utah Code Sections Affected by Coordination Clause:**

602 **26-2-2**, as last amended by Laws of Utah 2022, Chapter 415

603 **26-2-11**, as last amended by Laws of Utah 1995, Chapter 202

604 **26B-8-101**, as enacted by Laws of Utah 2022, Chapter 255

605 **26B-8-111**, Utah Code Annotated 1953

606

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

608 Section 1. Section **26B-3-101** is amended to read:

609 **CHAPTER 3. HEALTH CARE - ADMINISTRATION AND ASSISTANCE**

610 **Part 1. Health Care Assistance**

611 **26B-3-101. Definitions.**

612 [Reserved]

613 As used in this chapter:

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

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

618 (3) "Division" means the Division of Integrated Healthcare within the department,
619 established under Section **26B-3-102**.

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

622 (5) "Medicaid program" means the state program for medical assistance for persons

623 who are eligible under the state plan adopted pursuant to Title XIX of the federal Social
624 Security Act.

625 (6) "Medical assistance" means services furnished or payments made to or on behalf of
626 a member.

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

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

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

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

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

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

637 (9) "Recipient" means a person who has received medical assistance under the
638 Medicaid program.

639 Section 2. Section **26B-3-102**, which is renumbered from Section 26-18-2.1 is
640 renumbered and amended to read:

641 **~~[26-18-2.1].~~ 26B-3-102. Division -- Creation.**

642 There is created, within the department, the Division of [~~Medicaid and Health~~
643 ~~Financing~~] Integrated Healthcare which shall be responsible for implementing, organizing, and
644 maintaining the Medicaid program and the Children's Health Insurance Program established in
645 Section [~~26-40-103~~] 26B-3-902, in accordance with the provisions of this chapter and
646 applicable federal law.

647 Section 3. Section **26B-3-103**, which is renumbered from Section 26-18-2.2 is
648 renumbered and amended to read:

649 **~~[26-18-2.2].~~ 26B-3-103. State Medicaid director -- Appointment --**

650 **Responsibilities.**

651 (1) The state Medicaid director shall be appointed by the governor, after consultation
652 with the executive director, with the advice and consent of the Senate.

653 (2) The state Medicaid director may employ other employees as necessary to
654 implement the provisions of this chapter, and shall:

655 ~~[(1)]~~ (a) administer the responsibilities of the division as set forth in this chapter;

656 ~~[(2)]~~ (b) administer the division's budget; and

657 ~~[(3)]~~ (c) establish and maintain a state plan for the Medicaid program in compliance
658 with federal law and regulations.

659 Section 4. Section **26B-3-104**, which is renumbered from Section 26-18-2.3 is
660 renumbered and amended to read:

661 ~~[26-18-2.3].~~ **26B-3-104. Division responsibilities -- Emphasis -- Periodic**
662 **assessment.**

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

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

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

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

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

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

- 677 (b) preadmission certification of nonemergency admissions;
- 678 (c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;
- 679 (d) second surgical opinions;
- 680 (e) procedures for encouraging the use of outpatient services;
- 681 (f) consistent with Sections [~~26-18-2.4~~] 26B-3-105 and ~~58-17b-606~~, a Medicaid drug
- 682 program;
- 683 (g) coordination of benefits; and
- 684 (h) review and exclusion of providers who are not cost effective or who have abused
- 685 the Medicaid program, in accordance with the procedures and provisions of federal law and
- 686 regulation.

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

691 (4) (a) The department shall ensure Medicaid program integrity by conducting internal
692 audits of the Medicaid program for efficiencies, best practices, and cost avoidance.

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

696 Section 5. Section **26B-3-105**, which is renumbered from Section 26-18-2.4 is
697 renumbered and amended to read:

698 ~~[26-18-2.4]~~. **26B-3-105**. **Medicaid drug program -- Preferred drug list.**

699 (1) A Medicaid drug program developed by the department under Subsection
700 [~~26-18-2.3~~] 26B-3-104(2)(f):

701 (a) shall, notwithstanding Subsection [~~26-18-2.3~~] 26B-3-104(1)(b), be based on clinical
702 and cost-related factors which include medical necessity as determined by a provider in
703 accordance with administrative rules established by the Drug Utilization Review Board;

704 (b) may include therapeutic categories of drugs that may be exempted from the drug
705 program;

706 (c) may include placing some drugs, except the drugs described in Subsection (2), on a
707 preferred drug list:

708 (i) to the extent determined appropriate by the department; and

709 (ii) in the manner described in Subsection (3) for psychotropic drugs;

710 (d) notwithstanding the requirements of ~~[Part 2,]~~ Sections 26B-3-302 through
711 26B-3-309 regarding the Drug Utilization Review Board, and except as provided in Subsection
712 (3), shall immediately implement the prior authorization requirements for a nonpreferred drug
713 that is in the same therapeutic class as a drug that is:

714 (i) on the preferred drug list on the date that this act takes effect; or

715 (ii) added to the preferred drug list after this act takes effect; and

716 (e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior
717 authorization requirements established under Subsections (1)(c) and (d) which shall permit a
718 health care provider or the health care provider's agent to obtain a prior authorization override
719 of the preferred drug list through the department's pharmacy prior authorization review process,
720 and which shall:

721 (i) provide either telephone or fax approval or denial of the request within 24 hours of
722 the receipt of a request that is submitted during normal business hours of Monday through
723 Friday from 8 a.m. to 5 p.m.;

724 (ii) provide for the dispensing of a limited supply of a requested drug as determined
725 appropriate by the department in an emergency situation, if the request for an override is
726 received outside of the department's normal business hours; and

727 (iii) require the health care provider to provide the department with documentation of
728 the medical need for the preferred drug list override in accordance with criteria established by
729 the department in consultation with the Pharmacy and Therapeutics Committee.

730 (2) (a) ~~[For purposes of]~~ As used in this Subsection (2):

- 731 (i) "Immunosuppressive drug":
732 (A) means a drug that is used in immunosuppressive therapy to inhibit or prevent
733 activity of the immune system to aid the body in preventing the rejection of transplanted organs
734 and tissue; and
735 (B) does not include drugs used for the treatment of autoimmune disease or diseases
736 that are most likely of autoimmune origin.
- 737 (ii) "Stabilized" means a health care provider has documented in the patient's medical
738 chart that a patient has achieved a stable or steadfast medical state within the past 90 days using
739 a particular psychotropic drug.
- 740 (b) A preferred drug list developed under the provisions of this section may not include
741 an immunosuppressive drug.
- 742 (c) (i) The state Medicaid program shall reimburse for a prescription for an
743 immunosuppressive drug as written by the health care provider for a patient who has undergone
744 an organ transplant.
- 745 (ii) For purposes of Subsection [58-17b-606\(4\)](#), and with respect to patients who have
746 undergone an organ transplant, the prescription for a particular immunosuppressive drug as
747 written by a health care provider meets the criteria of demonstrating to the department a
748 medical necessity for dispensing the prescribed immunosuppressive drug.
- 749 (d) Notwithstanding the requirements of [~~Part 2,~~] [Sections 26B-3-302 through](#)
750 [26B-3-309 regarding the Drug Utilization Review Board](#), the state Medicaid drug program may
751 not require the use of step therapy for immunosuppressive drugs without the written or oral
752 consent of the health care provider and the patient.
- 753 (e) The department may include a sedative hypnotic on a preferred drug list in
754 accordance with Subsection (2)(f).
- 755 (f) The department shall grant a prior authorization for a sedative hypnotic that is not
756 on the preferred drug list under Subsection (2)(e), if the health care provider has documentation
757 related to one of the following conditions for the Medicaid client:

758 (i) a trial and failure of at least one preferred agent in the drug class, including the
759 name of the preferred drug that was tried, the length of therapy, and the reason for the
760 discontinuation;

761 (ii) detailed evidence of a potential drug interaction between current medication and
762 the preferred drug;

763 (iii) detailed evidence of a condition or contraindication that prevents the use of the
764 preferred drug;

765 (iv) objective clinical evidence that a patient is at high risk of adverse events due to a
766 therapeutic interchange with a preferred drug;

767 (v) the patient is a new or previous Medicaid client with an existing diagnosis
768 previously stabilized with a nonpreferred drug; or

769 (vi) other valid reasons as determined by the department.

770 (g) A prior authorization granted under Subsection (2)(f) is valid for one year from the
771 date the department grants the prior authorization and shall be renewed in accordance with
772 Subsection (2)(f).

773 (3) (a) [~~For purposes of~~] As used in this Subsection (3), "psychotropic drug" means the
774 following classes of drugs:

775 (i) atypical anti-psychotic;

776 (ii) anti-depressant;

777 (iii) anti-convulsant/mood stabilizer;

778 (iv) anti-anxiety; and

779 (v) attention deficit hyperactivity disorder stimulant.

780 (b) (i) The department shall develop a preferred drug list for psychotropic drugs.

781 (ii) Except as provided in Subsection (3)(d), a preferred drug list for psychotropic
782 drugs developed under this section shall allow a health care provider to override the preferred
783 drug list by writing "dispense as written" on the prescription for the psychotropic drug.

784 (iii) A health care provider may not override Section 58-17b-606 by writing "dispense

785 as written" on a prescription.

786 (c) The department, and a Medicaid accountable care organization that is responsible
787 for providing behavioral health, shall:

788 (i) establish a system to:

789 (A) track health care provider prescribing patterns for psychotropic drugs;

790 (B) educate health care providers who are not complying with the preferred drug list;

791 and

792 (C) implement peer to peer education for health care providers whose prescribing
793 practices continue to not comply with the preferred drug list; and

794 (ii) determine whether health care provider compliance with the preferred drug list is at
795 least:

796 (A) 55% of prescriptions by July 1, 2017;

797 (B) 65% of prescriptions by July 1, 2018; and

798 (C) 75% of prescriptions by July 1, 2019.

799 (d) Beginning October 1, 2019, the department shall eliminate the dispense as written
800 override for the preferred drug list, and shall implement a prior authorization system for
801 psychotropic drugs, in accordance with Subsection (2)(f), if by July 1, 2019, the department has
802 not realized annual savings from implementing the preferred drug list for psychotropic drugs of
803 at least \$750,000 General Fund savings.

804 Section 6. Section **26B-3-106**, which is renumbered from Section 26-18-2.5 is
805 renumbered and amended to read:

806 ~~[26-18-2.5]~~. **26B-3-106. Simplified enrollment and renewal process for Medicaid**
807 **and other state medical programs -- Financial institutions.**

808 (1) The department may apply for grants and accept donations to make technology
809 system improvements necessary to implement a simplified enrollment and renewal process for
810 the Medicaid program, Utah Premium Partnership, and Primary Care Network Demonstration
811 Project programs.

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

- 815 (i) uses automated data exchanges to the maximum extent feasible; and
- 816 (ii) requires a financial institution each month to provide the name, record address,
817 Social Security number, other taxpayer identification number, or other identifying information
818 for each applicant or enrollee who maintains an account at the financial institution.

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

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

823 (d) The department may disclose a financial record obtained from a financial institution
824 under this section only for the purpose of, and to the extent necessary in, verifying eligibility as
825 provided in this section and Section [\[26-40-105\]](#) [26B-3-903](#).

826 Section 7. Section **26B-3-107**, which is renumbered from Section 26-18-2.6 is
827 renumbered and amended to read:

828 **~~[26-18-2.6]~~. 26B-3-107. Dental benefits.**

829 (1) (a) Except as provided in Subsection (8), the division may establish a competitive
830 bid process to bid out Medicaid dental benefits under this chapter.

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

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

- 834 (a) ability to manage dental expenses;
- 835 (b) proven ability to handle dental insurance;
- 836 (c) efficiency of claim paying procedures;
- 837 (d) provider contracting, discounts, and adequacy of network; and
- 838 (e) other criteria established by the department.

839 (3) The division shall request bids for the program's benefits at least once every five
840 years.

841 (4) The division's contract with dental plans for the program's benefits shall include
842 risk sharing provisions in which the dental plan must accept 100% of the risk for any difference
843 between the division's premium payments per client and actual dental expenditures.

844 (5) The division may not award contracts to:

845 (a) more than three responsive bidders under this section; or

846 (b) an insurer that does not have a current license in the state.

847 (6) (a) The division may cancel the request for proposals if:

848 (i) there are no responsive bidders; or

849 (ii) the division determines that accepting the bids would increase the program's costs.

850 (b) If the division cancels a request for proposal or a contract that results from a request
851 for proposal described in Subsection (6)(a), the division shall report to the Health and Human
852 Services Interim Committee regarding the reasons for the decision.

853 (7) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.

854 (8) (a) The division may:

855 (i) establish a dental health care delivery system and payment reform pilot program for
856 Medicaid dental benefits to increase access to cost effective and quality dental health care by
857 increasing the number of dentists available for Medicaid dental services; and

858 (ii) target specific Medicaid populations or geographic areas in the state.

859 (b) The pilot program shall establish compensation models for dentists and dental
860 hygienists that:

861 (i) increase access to quality, cost effective dental care; and

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

865 (c) The division may amend the state plan and apply to the Secretary of the United

866 States Department of Health and Human Services for waivers or pilot programs if necessary to
867 establish the new dental care delivery and payment reform model.

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

870 (9) (a) As used in this Subsection (9), "dental hygienist" means an individual who is
871 licensed as a dental hygienist under Section 58-69-301.

872 (b) The department shall reimburse a dental hygienist for dental services performed in
873 a public health setting and in accordance with Subsection (9)(c) beginning on the earlier of:

874 (i) January 1, 2023; or

875 (ii) 30 days after the date on which the replacement of the department's Medicaid
876 Management Information System software is complete.

877 (c) The department shall reimburse a dental hygienist directly for a service provided
878 through the Medicaid program if:

879 (i) the dental hygienist requests to be reimbursed directly; and

880 (ii) the dental hygienist provides the service within the scope of practice described in
881 Section 58-69-801.

882 (d) Before November 30 of each year in which the department reimburses dental
883 hygienists in accordance with Subsection (9)(c), the department shall report to the Health and
884 Human Services Interim Committee, for the previous fiscal year:

885 (i) the number and geographic distribution of dental hygienists who requested to be
886 reimbursed directly;

887 (ii) the total number of Medicaid enrollees who were served by a dental hygienist who
888 were reimbursed under this Subsection (9);

889 (iii) the total amount reimbursed directly to dental hygienists under this Subsection (9);

890 (iv) the specific services and billing codes that are reimbursed under this Subsection
891 (9); and

892 (v) the aggregate amount reimbursed for each service and billing code described in

893 Subsection (9)(d)(iv).

894 (e) (i) Except as provided in this Subsection (9), nothing in this Subsection (9) shall be
895 interpreted as expanding or otherwise altering the limitations and scope of practice for a dental
896 hygienist.

897 (ii) A dental hygienist may only directly bill and receive compensation for billing codes
898 that fall within the scope of practice of a dental hygienist.

899 Section 8. Section **26B-3-108**, which is renumbered from Section 26-18-3 is
900 renumbered and amended to read:

901 ~~[26-18-3]~~. **26B-3-108**. **Administration of Medicaid program by department --**
902 **Reporting to the Legislature -- Disciplinary measures and sanctions -- Funds collected --**
903 **Eligibility standards -- Internal audits -- Health opportunity accounts.**

904 (1) The department shall be the single state agency responsible for the administration
905 of the Medicaid program in connection with the United States Department of Health and
906 Human Services pursuant to Title XIX of the Social Security Act.

907 (2) (a) The department shall implement the Medicaid program through administrative
908 rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking
909 Act, the requirements of Title XIX, and applicable federal regulations.

910 (b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules
911 necessary to implement the program:

912 (i) the standards used by the department for determining eligibility for Medicaid
913 services;

914 (ii) the services and benefits to be covered by the Medicaid program;

915 (iii) reimbursement methodologies for providers under the Medicaid program; and

916 (iv) a requirement that:

917 (A) a person receiving Medicaid services shall participate in the electronic exchange of
918 clinical health records established in accordance with Section ~~[26-1-37]~~ 26B-8-411 unless the
919 individual opts out of participation;

920 (B) prior to enrollment in the electronic exchange of clinical health records the enrollee
921 shall receive notice of enrollment in the electronic exchange of clinical health records and the
922 right to opt out of participation at any time; and

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

926 (3) (a) The department shall, in accordance with Subsection (3)(b), report to the Social
927 Services Appropriations Subcommittee when the department:

- 928 (i) implements a change in the Medicaid State Plan;
- 929 (ii) initiates a new Medicaid waiver;
- 930 (iii) initiates an amendment to an existing Medicaid waiver;
- 931 (iv) applies for an extension of an application for a waiver or an existing Medicaid

932 waiver;

933 (v) applies for or receives approval for a change in any capitation rate within the
934 Medicaid program; or

935 (vi) initiates a rate change that requires public notice under state or federal law.

936 (b) The report required by Subsection (3)(a) shall:

937 (i) be submitted to the Social Services Appropriations Subcommittee prior to the
938 department implementing the proposed change; and

939 (ii) include:

940 (A) a description of the department's current practice or policy that the department is
941 proposing to change;

942 (B) an explanation of why the department is proposing the change;

943 (C) the proposed change in services or reimbursement, including a description of the
944 effect of the change;

945 (D) the effect of an increase or decrease in services or benefits on individuals and
946 families;

947 (E) the degree to which any proposed cut may result in cost-shifting to more expensive
948 services in health or human service programs; and

949 (F) the fiscal impact of the proposed change, including:

950 (I) the effect of the proposed change on current or future appropriations from the
951 Legislature to the department;

952 (II) the effect the proposed change may have on federal matching dollars received by
953 the state Medicaid program;

954 (III) any cost shifting or cost savings within the department's budget that may result
955 from the proposed change; and

956 (IV) identification of the funds that will be used for the proposed change, including any
957 transfer of funds within the department's budget.

958 (4) Any rules adopted by the department under Subsection (2) are subject to review and
959 reauthorization by the Legislature in accordance with Section [63G-3-502](#).

960 (5) The department may, in its discretion, contract with [~~the Department of Human~~
961 ~~Services or~~] other qualified agencies for services in connection with the administration of the
962 Medicaid program, including:

963 (a) the determination of the eligibility of individuals for the program;

964 (b) recovery of overpayments; and

965 (c) consistent with Section [~~26-20-13~~] [26B-3-1113](#), and to the extent permitted by law
966 and quality control services, enforcement of fraud and abuse laws.

967 (6) The department shall provide, by rule, disciplinary measures and sanctions for
968 Medicaid providers who fail to comply with the rules and procedures of the program, provided
969 that sanctions imposed administratively may not extend beyond:

970 (a) termination from the program;

971 (b) recovery of claim reimbursements incorrectly paid; and

972 (c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

973 (7) (a) Funds collected as a result of a sanction imposed under Section 1919 of Title

974 XIX of the federal Social Security Act shall be deposited in the General Fund as dedicated
975 credits to be used by the division in accordance with the requirements of Section 1919 of Title
976 XIX of the federal Social Security Act.

977 (b) In accordance with Section [63J-1-602.2](#), sanctions collected under this Subsection
978 (7) are nonlapsing.

979 (8) (a) In determining whether an applicant or recipient is eligible for a service or
980 benefit under this part or ~~[Chapter 40]~~ Part 9, Utah Children's Health Insurance ~~[Act]~~ Program,
981 the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger
982 vehicle designated by the applicant or recipient.

983 (b) Before Subsection (8)(a) may be applied:

984 (i) the federal government shall:

985 (A) determine that Subsection (8)(a) may be implemented within the state's existing
986 public assistance-related waivers as of January 1, 1999;

987 (B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or

988 (C) determine that the state's waivers that permit dual eligibility determinations for
989 cash assistance and Medicaid are no longer valid; and

990 (ii) the department shall determine that Subsection (8)(a) can be implemented within
991 existing funding.

992 (9) (a) ~~[For purposes of]~~ As used in this Subsection (9):

993 (i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as
994 defined in 42 U.S.C. Sec. 1382c(a)(1); and

995 (ii) "spend down" means an amount of income in excess of the allowable income
996 standard that shall be paid in cash to the department or incurred through the medical services
997 not paid by Medicaid.

998 (b) In determining whether an applicant or recipient who is aged, blind, or has a
999 disability is eligible for a service or benefit under this chapter, the department shall use 100%
1000 of the federal poverty level as:

- 1001 (i) the allowable income standard for eligibility for services or benefits; and
1002 (ii) the allowable income standard for eligibility as a result of spend down.
- 1003 (10) The department shall conduct internal audits of the Medicaid program.
- 1004 (11) (a) The department may apply for and, if approved, implement a demonstration
1005 program for health opportunity accounts, as provided for in 42 U.S.C. Sec. 1396u-8.
- 1006 (b) A health opportunity account established under Subsection (11)(a) shall be an
1007 alternative to the existing benefits received by an individual eligible to receive Medicaid under
1008 this chapter.
- 1009 (c) Subsection (11)(a) is not intended to expand the coverage of the Medicaid program.
- 1010 (12) (a) (i) The department shall apply for, and if approved, implement an amendment
1011 to the state plan under this Subsection (12) for benefits for:
- 1012 (A) medically needy pregnant women;
1013 (B) medically needy children; and
1014 (C) medically needy parents and caretaker relatives.
- 1015 (ii) The department may implement the eligibility standards of Subsection (12)(b) for
1016 eligibility determinations made on or after the date of the approval of the amendment to the
1017 state plan.
- 1018 (b) In determining whether an applicant is eligible for benefits described in Subsection
1019 (12)(a)(i), the department shall:
- 1020 (i) disregard resources held in an account in the savings plan created under Title 53B,
1021 Chapter 8a, Utah Educational Savings Plan, if the beneficiary of the account is:
- 1022 (A) under the age of 26; and
1023 (B) living with the account owner, as that term is defined in Section [53B-8a-102](#), or
1024 temporarily absent from the residence of the account owner; and
- 1025 (ii) include the withdrawals from an account in the Utah Educational Savings Plan as
1026 resources for a benefit determination, if the withdrawal was not used for qualified higher
1027 education costs as that term is defined in Section [53B-8a-102.5](#).

1028 (13) (a) The department may not deny or terminate eligibility for Medicaid solely
1029 because an individual is:

1030 (i) incarcerated; and

1031 (ii) not an inmate as defined in Section 64-13-1.

1032 (b) Subsection (13)(a) does not require the Medicaid program to provide coverage for
1033 any services for an individual while the individual is incarcerated.

1034 (14) The department is a party to, and may intervene at any time in, any judicial or
1035 administrative action:

1036 (a) to which the Department of Workforce Services is a party; and

1037 (b) that involves medical assistance under[:] this chapter.

1038 [~~(i) Title 26, Chapter 18, Medical Assistance Act, or~~]

1039 [~~(ii) Title 26, Chapter 40, Utah Children's Health Insurance Act.~~]

1040 Section 9. Section **26B-3-109**, which is renumbered from Section 26-18-3.1 is
1041 renumbered and amended to read:

1042 ~~[26-18-3.1].~~ **26B-3-109. Medicaid expansion.**

1043 (1) The purpose of this section is to expand the coverage of the Medicaid program to
1044 persons who are in categories traditionally not served by that program.

1045 (2) Within appropriations from the Legislature, the department may amend the state
1046 plan for medical assistance to provide for eligibility for Medicaid:

1047 (a) on or after July 1, 1994, for children 12 to 17 years old who live in households
1048 below the federal poverty income guideline; and

1049 (b) on or after July 1, 1995, for persons who have incomes below the federal poverty
1050 income guideline and who are aged, blind, or have a disability.

1051 (3) (a) Within appropriations from the Legislature, on or after July 1, 1996, the
1052 Medicaid program may provide for eligibility for persons who have incomes below the federal
1053 poverty income guideline.

1054 (b) In order to meet the provisions of this subsection, the department may seek

1055 approval for a demonstration project under 42 U.S.C. Sec. 1315 from the secretary of the
1056 United States Department of Health and Human Services.

1057 (4) The Medicaid program shall provide for eligibility for persons as required by
1058 Subsection [~~26-18-3.9~~] 26B-3-113(2).

1059 (5) Services available for persons described in this section shall include required
1060 Medicaid services and may include one or more optional Medicaid services if those services
1061 are funded by the Legislature. The department may also require persons described in
1062 Subsections (1) through (3) to meet an asset test.

1063 Section 10. Section **26B-3-110**, which is renumbered from Section 26-18-3.5 is
1064 renumbered and amended to read:

1065 ~~[26-18-3.5]~~. **26B-3-110**. **Copayments by recipients -- Employer sponsored plans.**

1066 (1) The department shall selectively provide for enrollment fees, premiums,
1067 deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and
1068 parents, within the limitations of federal law and regulation.

1069 (2) Beginning May 1, 2006, within appropriations by the Legislature and as a means to
1070 increase health care coverage among the uninsured, the department shall take steps to promote
1071 increased participation in employer sponsored health insurance, including:

1072 (a) maximizing the health insurance premium subsidy provided under the state's 1115
1073 demonstration waiver by:

1074 (i) ensuring that state funds are matched by federal funds to the greatest extent
1075 allowable; and

1076 (ii) as the department determines appropriate, seeking federal approval to do one or
1077 more of the following:

1078 (A) eliminate or otherwise modify the annual enrollment fee;

1079 (B) eliminate or otherwise modify the schedule used to determine the level of subsidy
1080 provided to an enrollee each year;

1081 (C) reduce the maximum number of participants allowable under the subsidy program;

1082 or

1083 (D) otherwise modify the program in a manner that promotes enrollment in employer
1084 sponsored health insurance; and

1085 (b) exploring the use of other options, including the development of a waiver under the
1086 Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

1087 Section 11. Section **26B-3-111**, which is renumbered from Section 26-18-3.6 is
1088 renumbered and amended to read:

1089 ~~[26-18-3.6]~~. **26B-3-111. Income and resources from institutionalized spouses.**

1090 (1) As used in this section:

1091 (a) "Community spouse" means the spouse of an institutionalized spouse.

1092 (b) (i) "Community spouse monthly income allowance" means an amount by which the
1093 minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly
1094 income otherwise available to the community spouse, determined without regard to the
1095 allowance, except as provided in Subsection (1)(b)(ii).

1096 (ii) If a court has entered an order against an institutionalized spouse for monthly
1097 income for the support of the community spouse, the community spouse monthly income
1098 allowance for the spouse may not be less than the amount of the monthly income so ordered.

1099 (c) "Community spouse resource allowance" is the amount of combined resources that
1100 are protected for a community spouse living in the community, which the division shall
1101 establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
1102 Rulemaking Act, based on the amounts established by the United States Department of Health
1103 and Human Services.

1104 (d) "Excess shelter allowance" for a community spouse means the amount by which the
1105 sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case
1106 of condominium or cooperative, required maintenance charge, for the community spouse's
1107 principal residence and the spouse's actual expenses for electricity, natural gas, and water
1108 utilities or, at the discretion of the department, the federal standard utility allowance under

1109 SNAP as defined in Section [35A-1-102](#), exceeds 30% of the amount described in Subsection
1110 (9).

1111 (e) "Family member" means a minor dependent child, dependent parents, or dependent
1112 sibling of the institutionalized spouse or community spouse who are residing with the
1113 community spouse.

1114 (f) (i) "Institutionalized spouse" means a person who is residing in a nursing facility
1115 and is married to a spouse who is not in a nursing facility.

1116 (ii) An "institutionalized spouse" does not include a person who is not likely to reside
1117 in a nursing facility for at least 30 consecutive days.

1118 (g) "Nursing care facility" means the same as that term is defined in Section [~~26-21-2~~]
1119 [26B-2-201](#).

1120 (2) The division shall comply with this section when determining eligibility for
1121 medical assistance for an institutionalized spouse.

1122 (3) For services furnished during a calendar year beginning on or after January 1, 1999,
1123 the community spouse resource allowance shall be increased by the division by an amount as
1124 determined annually by CMS.

1125 (4) The division shall compute, as of the beginning of the first continuous period of
1126 institutionalization of the institutionalized spouse:

1127 (a) the total value of the resources to the extent either the institutionalized spouse or
1128 the community spouse has an ownership interest; and

1129 (b) a spousal share, which is 1/2 of the resources described in Subsection (4)(a).

1130 (5) At the request of an institutionalized spouse or a community spouse, at the
1131 beginning of the first continuous period of institutionalization of the institutionalized spouse
1132 and upon the receipt of relevant documentation of resources, the division shall promptly assess
1133 and document the total value described in Subsection (4)(a) and shall provide a copy of that
1134 assessment and documentation to each spouse and shall retain a copy of the assessment. When
1135 the division provides a copy of the assessment, it shall include a notice stating that the spouse

1136 may request a hearing under Subsection (11).

1137 (6) When determining eligibility for medical assistance under this chapter:

1138 (a) Except as provided in Subsection (6)(b), all resources held by either the
1139 institutionalized spouse, community spouse, or both, are considered to be available to the
1140 institutionalized spouse.

1141 (b) Resources are considered to be available to the institutionalized spouse only to the
1142 extent that the amount of those resources exceeds the community spouse resource allowance at
1143 the time of application for medical assistance under this chapter.

1144 (7) (a) The division may not find an institutionalized spouse to be ineligible for
1145 medical assistance by reason of resources determined under Subsection (5) to be available for
1146 the cost of care when:

1147 (i) the institutionalized spouse has assigned to the state any rights to support from the
1148 community spouse;

1149 (ii) except as provided in Subsection (7)(b), the institutionalized spouse lacks the
1150 ability to execute an assignment due to physical or mental impairment; or

1151 (iii) the division determines that denial of medical assistance would cause an undue
1152 burden.

1153 (b) Subsection (7)(a)(ii) does not prevent the division from seeking a court order for an
1154 assignment of support.

1155 (8) During the continuous period in which an institutionalized spouse is in an
1156 institution and after the month in which an institutionalized spouse is eligible for medical
1157 assistance, the resources of the community spouse may not be considered to be available to the
1158 institutionalized spouse.

1159 (9) When an institutionalized spouse is determined to be eligible for medical
1160 assistance, in determining the amount of the spouse's income that is to be applied monthly for
1161 the cost of care in the nursing care facility, the division shall deduct from the spouse's monthly
1162 income the following amounts in the following order:

- 1163 (a) a personal needs allowance, the amount of which is determined by the division;
1164 (b) a community spouse monthly income allowance, but only to the extent that the
1165 income of the institutionalized spouse is made available to, or for the benefit of, the community
1166 spouse;
- 1167 (c) a family allowance for each family member, equal to at least 1/3 of the amount that
1168 the amount described in Subsection (10)(a) exceeds the amount of the family member's
1169 monthly income; and
- 1170 (d) amounts for incurred expenses for the medical or remedial care for the
1171 institutionalized spouse.
- 1172 (10) The division shall establish a minimum monthly maintenance needs allowance for
1173 each community spouse that includes:
- 1174 (a) an amount established by the division by rule made in accordance with Title 63G,
1175 Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the
1176 United States Department of Health and Human Services; and
- 1177 (b) an excess shelter allowance.
- 1178 (11) (a) An institutionalized spouse or a community spouse may request a hearing with
1179 respect to the determinations described in Subsections (11)(e)(i) through (v) if an application
1180 for medical assistance has been made on behalf of the institutionalized spouse.
- 1181 (b) A hearing under this subsection regarding the community spouse resource
1182 allowance shall be held by the division within 90 days from the date of the request for the
1183 hearing.
- 1184 (c) If either spouse establishes that the community spouse needs income, above the
1185 level otherwise provided by the minimum monthly maintenance needs allowance, due to
1186 exceptional circumstances resulting in significant financial duress, there shall be substituted,
1187 for the minimum monthly maintenance needs allowance provided under Subsection (10), an
1188 amount adequate to provide additional income as is necessary.
- 1189 (d) If either spouse establishes that the community spouse resource allowance, in

1190 relation to the amount of income generated by the allowance is inadequate to raise the
1191 community spouse's income to the minimum monthly maintenance needs allowance, there shall
1192 be substituted, for the community spouse resource allowance, an amount adequate to provide a
1193 minimum monthly maintenance needs allowance.

1194 (e) A hearing may be held under this subsection if either the institutionalized spouse or
1195 community spouse is dissatisfied with a determination of:

- 1196 (i) the community spouse monthly income allowance;
- 1197 (ii) the amount of monthly income otherwise available to the community spouse;
- 1198 (iii) the computation of the spousal share of resources under Subsection (4);
- 1199 (iv) the attribution of resources under Subsection (6); or
- 1200 (v) the determination of the community spouse resource allocation.

1201 (12) (a) An institutionalized spouse may transfer an amount equal to the community
1202 spouse resource allowance, but only to the extent the resources of the institutionalized spouse
1203 are transferred to or for the sole benefit of the community spouse.

1204 (b) The transfer under Subsection (12)(a) shall be made as soon as practicable after the
1205 date of the initial determination of eligibility, taking into account the time necessary to obtain a
1206 court order under Subsection (12)(c).

1207 (c) [~~Chapter 19, Medical Benefits Recovery Act~~] Part 10, Medical Benefits Recovery,
1208 does not apply if a court has entered an order against an institutionalized spouse for the support
1209 of the community spouse.

1210 Section 12. Section **26B-3-112**, which is renumbered from Section 26-18-3.8 is
1211 renumbered and amended to read:

1212 ~~[26-18-3.8].~~ **26B-3-112. Maximizing use of premium assistance programs --**
1213 **Utah's Premium Partnership for Health Insurance.**

1214 (1) (a) The department shall seek to maximize the use of Medicaid and Children's
1215 Health Insurance Program funds for assistance in the purchase of private health insurance
1216 coverage for Medicaid-eligible and non-Medicaid-eligible individuals.

1217 (b) The department's efforts to expand the use of premium assistance shall:
1218 (i) include, as necessary, seeking federal approval under all Medicaid and Children's
1219 Health Insurance Program premium assistance provisions of federal law, including provisions
1220 of [~~the Patient Protection and Affordable Care Act, Public Law 111-148~~] PPACA;

1221 (ii) give priority to, but not be limited to, expanding the state's Utah Premium
1222 Partnership for Health Insurance Program, including as required under Subsection (2); and
1223 (iii) encourage the enrollment of all individuals within a household in the same plan,
1224 where possible, including enrollment in a plan that allows individuals within the household
1225 transitioning out of Medicaid to retain the same network and benefits they had while enrolled
1226 in Medicaid.

1227 (2) The department shall seek federal approval of an amendment to the state's Utah
1228 Premium Partnership for Health Insurance program to adjust the eligibility determination for
1229 single adults and parents who have an offer of employer sponsored insurance. The amendment
1230 shall:

1231 (a) be within existing appropriations for the Utah Premium Partnership for Health
1232 Insurance program; and

1233 (b) provide that adults who are up to 200% of the federal poverty level are eligible for
1234 premium subsidies in the Utah Premium Partnership for Health Insurance program.

1235 (3) For the fiscal year 2020-21, the department shall seek authority to increase the
1236 maximum premium subsidy per month for adults under the Utah Premium Partnership for
1237 Health Insurance program to \$300.

1238 (4) Beginning with the fiscal year 2021-22, and in each subsequent fiscal year, the
1239 department may increase premium subsidies for single adults and parents who have an offer of
1240 employer-sponsored insurance to keep pace with the increase in insurance premium costs,
1241 subject to appropriation of additional funding.

1242 Section 13. Section **26B-3-113**, which is renumbered from Section 26-18-3.9 is
1243 renumbered and amended to read:

1244 ~~[26-18-3.9].~~ 26B-3-113. Expanding the Medicaid program.

1245 (1) As used in this section:

1246 ~~[(a) "CMS" means the Centers for Medicare and Medicaid Services in the United~~
1247 ~~States Department of Health and Human Services.]~~

1248 ~~[(b)]~~ (a) "Federal poverty level" means the same as that term is defined in Section
1249 ~~[26-18-411]~~ 26B-3-207.

1250 ~~[(c)]~~ (b) "Medicaid expansion" means an expansion of the Medicaid program in
1251 accordance with this section.

1252 ~~[(d)]~~ (c) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in
1253 Section ~~[26-36b-208]~~ 26B-1-315.

1254 (2) (a) As set forth in Subsections (2) through (5), eligibility criteria for the Medicaid
1255 program shall be expanded to cover additional low-income individuals.

1256 (b) The department shall continue to seek approval from CMS to implement the
1257 Medicaid waiver expansion as defined in Section ~~[26-18-415]~~ 26B-1-112.

1258 (c) The department may implement any provision described in Subsections
1259 ~~[26-18-415]~~ 26B-3-112(2)(b)(iii) through (viii) in a Medicaid expansion if the department
1260 receives approval from CMS to implement that provision.

1261 (3) The department shall expand the Medicaid program in accordance with this
1262 Subsection (3) if the department:

1263 (a) receives approval from CMS to:

1264 (i) expand Medicaid coverage to eligible individuals whose income is below 95% of
1265 the federal poverty level;

1266 (ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(b) for
1267 enrolling an individual in the Medicaid expansion under this Subsection (3); and

1268 (iii) permit the state to close enrollment in the Medicaid expansion under this
1269 Subsection (3) if the department has insufficient funds to provide services to new enrollment
1270 under the Medicaid expansion under this Subsection (3);

1271 (b) pays the state portion of costs for the Medicaid expansion under this Subsection (3)
1272 with funds from:

1273 (i) the Medicaid Expansion Fund;

1274 (ii) county contributions to the nonfederal share of Medicaid expenditures; or

1275 (iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid
1276 expenditures; and

1277 (c) closes the Medicaid program to new enrollment under the Medicaid expansion
1278 under this Subsection (3) if the department projects that the cost of the Medicaid expansion
1279 under this Subsection (3) will exceed the appropriations for the fiscal year that are authorized
1280 by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter
1281 1, Budgetary Procedures Act.

1282 (4) (a) The department shall expand the Medicaid program in accordance with this
1283 Subsection (4) if the department:

1284 (i) receives approval from CMS to:

1285 (A) expand Medicaid coverage to eligible individuals whose income is below 95% of
1286 the federal poverty level;

1287 (B) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for
1288 enrolling an individual in the Medicaid expansion under this Subsection (4); and

1289 (C) permit the state to close enrollment in the Medicaid expansion under this
1290 Subsection (4) if the department has insufficient funds to provide services to new enrollment
1291 under the Medicaid expansion under this Subsection (4);

1292 (ii) pays the state portion of costs for the Medicaid expansion under this Subsection (4)
1293 with funds from:

1294 (A) the Medicaid Expansion Fund;

1295 (B) county contributions to the nonfederal share of Medicaid expenditures; or

1296 (C) any other contributions, funds, or transfers from a nonstate agency for Medicaid
1297 expenditures; and

1298 (iii) closes the Medicaid program to new enrollment under the Medicaid expansion
1299 under this Subsection (4) if the department projects that the cost of the Medicaid expansion
1300 under this Subsection (4) will exceed the appropriations for the fiscal year that are authorized
1301 by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter
1302 1, Budgetary Procedures Act.

1303 (b) The department shall submit a waiver, an amendment to an existing waiver, or a
1304 state plan amendment to CMS to:

1305 (i) administer federal funds for the Medicaid expansion under this Subsection (4)
1306 according to a per capita cap developed by the department that includes an annual inflationary
1307 adjustment, accounts for differences in cost among categories of Medicaid expansion enrollees,
1308 and provides greater flexibility to the state than the current Medicaid payment model;

1309 (ii) limit, in certain circumstances as defined by the department, the ability of a
1310 qualified entity to determine presumptive eligibility for Medicaid coverage for an individual
1311 enrolled in a Medicaid expansion under this Subsection (4);

1312 (iii) impose a lock-out period if an individual enrolled in a Medicaid expansion under
1313 this Subsection (4) violates certain program requirements as defined by the department;

1314 (iv) allow an individual enrolled in a Medicaid expansion under this Subsection (4) to
1315 remain in the Medicaid program for up to a 12-month certification period as defined by the
1316 department; and

1317 (v) allow federal Medicaid funds to be used for housing support for eligible enrollees
1318 in the Medicaid expansion under this Subsection (4).

1319 (5) (a) (i) If CMS does not approve a waiver to expand the Medicaid program in
1320 accordance with Subsection (4)(a) on or before January 1, 2020, the department shall develop
1321 proposals to implement additional flexibilities and cost controls, including cost sharing tools,
1322 within a Medicaid expansion under this Subsection (5) through a request to CMS for a waiver
1323 or state plan amendment.

1324 (ii) The request for a waiver or state plan amendment described in Subsection (5)(a)(i)

1325 shall include:

1326 (A) a path to self-sufficiency for qualified adults in the Medicaid expansion that
1327 includes employment and training as defined in 7 U.S.C. Sec. 2015(d)(4); and

1328 (B) a requirement that an individual who is offered a private health benefit plan by an
1329 employer to enroll in the employer's health plan.

1330 (iii) The department shall submit the request for a waiver or state plan amendment
1331 developed under Subsection (5)(a)(i) on or before March 15, 2020.

1332 (b) Notwithstanding Sections [~~26-18-18~~] [26B-3-127](#) and [63J-5-204](#), and in accordance
1333 with this Subsection (5), eligibility for the Medicaid program shall be expanded to include all
1334 persons in the optional Medicaid expansion population under [~~the Patient Protection and~~
1335 ~~Affordable Care Act, Pub. L. No. 111-148~~] [PPACA](#) and the Health Care Education
1336 Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance,
1337 on the earlier of:

1338 (i) the day on which CMS approves a waiver to implement the provisions described in
1339 Subsections (5)(a)(ii)(A) and (B); or

1340 (ii) July 1, 2020.

1341 (c) The department shall seek a waiver, or an amendment to an existing waiver, from
1342 federal law to:

1343 (i) implement each provision described in Subsections [~~26-18-415~~]
1344 [26B-3-210](#)(2)(b)(iii) through (viii) in a Medicaid expansion under this Subsection (5);

1345 (ii) limit, in certain circumstances as defined by the department, the ability of a
1346 qualified entity to determine presumptive eligibility for Medicaid coverage for an individual
1347 enrolled in a Medicaid expansion under this Subsection (5); and

1348 (iii) impose a lock-out period if an individual enrolled in a Medicaid expansion under
1349 this Subsection (5) violates certain program requirements as defined by the department.

1350 (d) The eligibility criteria in this Subsection (5) shall be construed to include all
1351 individuals eligible for the health coverage improvement program under Section [~~26-18-411~~]

1352 [26B-3-207](#).

1353 (e) The department shall pay the state portion of costs for a Medicaid expansion under
1354 this Subsection (5) entirely from:

1355 (i) the Medicaid Expansion Fund;

1356 (ii) county contributions to the nonfederal share of Medicaid expenditures; or

1357 (iii) any other contributions, funds, or transfers from a nonstate agency for Medicaid
1358 expenditures.

1359 (f) If the costs of the Medicaid expansion under this Subsection (5) exceed the funds
1360 available under Subsection (5)(e):

1361 (i) the department may reduce or eliminate optional Medicaid services under this
1362 chapter; ~~and~~

1363 (ii) savings, as determined by the department, from the reduction or elimination of
1364 optional Medicaid services under Subsection (5)(f)(i) shall be deposited into the Medicaid
1365 Expansion Fund; and

1366 (iii) the department may submit to CMS a request for waivers, or an amendment of
1367 existing waivers, from federal law necessary to implement budget controls within the Medicaid
1368 program to address the deficiency.

1369 (g) If the costs of the Medicaid expansion under this Subsection (5) are projected by
1370 the department to exceed the funds available in the current fiscal year under Subsection (5)(e),
1371 including savings resulting from any action taken under Subsection (5)(f):

1372 (i) the governor shall direct the [~~Department of Health, Department of Human~~
1373 ~~Services,~~] department and Department of Workforce Services to reduce commitments and
1374 expenditures by an amount sufficient to offset the deficiency:

1375 (A) proportionate to the share of total current fiscal year General Fund appropriations
1376 for each of those agencies; and

1377 (B) up to 10% of each agency's total current fiscal year General Fund appropriations;

1378 (ii) the Division of Finance shall reduce allotments to the [~~Department of Health,~~

1379 ~~Department of Human Services,]~~ department and Department of Workforce Services by a
1380 percentage:

1381 (A) proportionate to the amount of the deficiency; and

1382 (B) up to 10% of each agency's total current fiscal year General Fund appropriations;

1383 and

1384 (iii) the Division of Finance shall deposit the total amount from the reduced allotments
1385 described in Subsection (5)(g)(ii) into the Medicaid Expansion Fund.

1386 (6) The department shall maximize federal financial participation in implementing this
1387 section, including by seeking to obtain any necessary federal approvals or waivers.

1388 (7) Notwithstanding Sections [17-43-201](#) and [17-43-301](#), a county does not have to
1389 provide matching funds to the state for the cost of providing Medicaid services to newly
1390 enrolled individuals who qualify for Medicaid coverage under a Medicaid expansion.

1391 (8) The department shall report to the Social Services Appropriations Subcommittee on
1392 or before November 1 of each year that a Medicaid expansion is operational:

1393 (a) the number of individuals who enrolled in the Medicaid expansion;

1394 (b) costs to the state for the Medicaid expansion;

1395 (c) estimated costs to the state for the Medicaid expansion for the current and
1396 following fiscal years;

1397 (d) recommendations to control costs of the Medicaid expansion; and

1398 (e) as calculated in accordance with Subsections ~~[26-36b-204]~~ [26B-3-506](#)(4) and
1399 ~~[26-36c-204]~~ [26B-3-606](#)(2), the state's net cost of the qualified Medicaid expansion.

1400 Section 14. Section **26B-3-114**, which is renumbered from Section 26-18-4 is
1401 renumbered and amended to read:

1402 ~~[26-18-4].~~ **26B-3-114. Department standards for eligibility under Medicaid --**
1403 **Funds for abortions.**

1404 (1) (a) The department may develop standards and administer policies relating to
1405 eligibility under the Medicaid program as long as they are consistent with Subsection ~~[26-18-3]~~

1406 [26B-4-704](#)(8).

1407 (b) An applicant receiving Medicaid assistance may be limited to particular types of
1408 care or services or to payment of part or all costs of care determined to be medically necessary.

1409 (2) The department may not provide any funds for medical, hospital, or other medical
1410 expenditures or medical services to otherwise eligible persons where the purpose of the
1411 assistance is to perform an abortion, unless the life of the mother would be endangered if an
1412 abortion were not performed.

1413 (3) Any employee of the department who authorizes payment for an abortion contrary
1414 to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of
1415 office.

1416 (4) Any person or organization that, under the guise of other medical treatment,
1417 provides an abortion under auspices of the Medicaid program is guilty of a third degree felony
1418 and subject to forfeiture of license to practice medicine or authority to provide medical services
1419 and treatment.

1420 Section 15. Section **26B-3-115**, which is renumbered from Section 26-18-5 is
1421 renumbered and amended to read:

1422 ~~[26-18-5]~~. **26B-3-115. Contracts for provision of medical services -- Federal**
1423 **provisions modifying department rules -- Compliance with Social Security Act.**

1424 (1) The department may contract with other public or private agencies to purchase or
1425 provide medical services in connection with the programs of the division. Where these
1426 programs are used by other government entities, contracts shall provide that other government
1427 entities, in compliance with state and federal law regarding intergovernmental transfers,
1428 transfer the state matching funds to the department in amounts sufficient to satisfy needs of the
1429 specified program.

1430 (2) Contract terms shall include provisions for maintenance, administration, and
1431 service costs.

1432 (3) If a federal legislative or executive provision requires modifications or revisions in

1433 an eligibility factor established under this chapter as a condition for participation in medical
1434 assistance, the department may modify or change its rules as necessary to qualify for
1435 participation.

1436 (4) The provisions of this section do not apply to department rules governing abortion.

1437 (5) The department shall comply with all pertinent requirements of the Social Security
1438 Act and all orders, rules, and regulations adopted thereunder when required as a condition of
1439 participation in benefits under the Social Security Act.

1440 Section 16. Section **26B-3-116**, which is renumbered from Section 26-18-5.5 is
1441 renumbered and amended to read:

1442 ~~[26-18-5.5]~~. **26B-3-116**. **Liability insurance required.**

1443 The Medicaid program may not reimburse a home health agency, as defined in Section
1444 ~~[26-21-2]~~ 26B-2-201, for home health services provided to an enrollee unless the home health
1445 agency has liability coverage of:

1446 (1) at least \$500,000 per incident; or

1447 (2) an amount established by department rule made in accordance with Title 63G,
1448 Chapter 3, Utah Administrative Rulemaking Act.

1449 Section 17. Section **26B-3-117**, which is renumbered from Section 26-18-6 is
1450 renumbered and amended to read:

1451 ~~[26-18-6]~~. **26B-3-117**. **Federal aid -- Authority of executive director.**

1452 (1) The executive director, with the approval of the governor, may bind the state to any
1453 executive or legislative provisions promulgated or enacted by the federal government which
1454 invite the state to participate in the distribution, disbursement or administration of any fund or
1455 service advanced, offered or contributed in whole or in part by the federal government for
1456 purposes consistent with the powers and duties of the department.

1457 (2) Such funds shall be used as provided in this chapter and be administered by the
1458 department for purposes related to medical assistance programs.

1459 Section 18. Section **26B-3-118**, which is renumbered from Section 26-18-7 is

1460 renumbered and amended to read:

1461 ~~[26-18-7]~~. **26B-3-118. Medical vendor rates.**

1462 (1) Medical vendor payments made to providers of services for and in behalf of
1463 recipient households shall be based upon predetermined rates from standards developed by the
1464 division in cooperation with providers of services for each type of service purchased by the
1465 division.

1466 (2) As far as possible, the rates paid for services shall be established in advance of the
1467 fiscal year for which funds are to be requested.

1468 Section 19. Section **26B-3-119**, which is renumbered from Section 26-18-8 is
1469 renumbered and amended to read:

1470 ~~[26-18-8]~~. **26B-3-119. Enforcement of public assistance statutes.**

1471 (1) The department shall enforce or contract for the enforcement of Sections
1472 [35A-1-503](#), [35A-3-108](#), [35A-3-110](#), [35A-3-111](#), [35A-3-112](#), and [35A-3-603](#) to the extent that
1473 these sections pertain to benefits conferred or administered by the division under this chapter,
1474 to the extent allowed under federal law or regulation.

1475 (2) The department may contract for services covered in Section [35A-3-111](#) insofar as
1476 that section pertains to benefits conferred or administered by the division under this chapter.

1477 Section 20. Section **26B-3-120**, which is renumbered from Section 26-18-9 is
1478 renumbered and amended to read:

1479 ~~[26-18-9]~~. **26B-3-120. Prohibited acts of state or local employees of Medicaid**
1480 **program -- Violation a misdemeanor.**

1481 (1) Each state or local employee responsible for the expenditure of funds under the
1482 state Medicaid program, each individual who formerly was such an officer or employee, and
1483 each partner of such an officer or employee is prohibited for a period of one year after
1484 termination of such responsibility from committing any act, the commission of which by an
1485 officer or employee of the United States Government, an individual who was such an officer or
1486 employee, or a partner of such an officer or employee is prohibited by Section 207 or Section

1487 208 of Title 18, United States Code.

1488 (2) Violation of this section is a class A misdemeanor.

1489 Section 21. Section **26B-3-121**, which is renumbered from Section 26-18-11 is
1490 renumbered and amended to read:

1491 ~~[26-18-11]~~. **26B-3-121. Rural hospitals.**

1492 (1) ~~[For purposes of]~~ As used in this section "rural hospital" means a hospital located
1493 outside of a standard metropolitan statistical area, as designated by the United States Bureau of
1494 the Census.

1495 (2) For purposes of the Medicaid program, the ~~[Division of Medicaid and Health~~
1496 ~~Financing]~~ division may not discriminate among rural hospitals on the basis of size.

1497 Section 22. Section **26B-3-122**, which is renumbered from Section 26-18-13 is
1498 renumbered and amended to read:

1499 ~~[26-18-13]~~. **26B-3-122. Telemedicine -- Reimbursement -- Rulemaking.**

1500 (1) (a) As used in this section, communication by telemedicine is considered
1501 face-to-face contact between a health care provider and a patient under the state's medical
1502 assistance program if:

1503 (i) the communication by telemedicine meets the requirements of administrative rules
1504 adopted in accordance with Subsection (3); and

1505 (ii) the health care services are eligible for reimbursement under the state's medical
1506 assistance program.

1507 (b) This Subsection (1) applies to any managed care organization that contracts with
1508 the state's medical assistance program.

1509 (2) The reimbursement rate for telemedicine services approved under this section:

1510 (a) shall be subject to reimbursement policies set by the state plan; and

1511 (b) may be based on:

1512 (i) a monthly reimbursement rate;

1513 (ii) a daily reimbursement rate; or

1514 (iii) an encounter rate.

1515 (3) The department shall adopt administrative rules in accordance with Title 63G,
1516 Chapter 3, Utah Administrative Rulemaking Act, which establish:

1517 (a) the particular telemedicine services that are considered face-to-face encounters for
1518 reimbursement purposes under the state's medical assistance program; and

1519 (b) the reimbursement methodology for the telemedicine services designated under
1520 Subsection (3)(a).

1521 Section 23. Section **26B-3-123**, which is renumbered from Section 26-18-13.5 is
1522 renumbered and amended to read:

1523 ~~[26-18-13.5]~~. **26B-3-123. Reimbursement of telemedicine services and**
1524 **telepsychiatric consultations.**

1525 (1) As used in this section:

1526 (a) "Telehealth services" means the same as that term is defined in Section ~~[26-60-102]~~
1527 [26B-4-704](#).

1528 (b) "Telemedicine services" means the same as that term is defined in Section
1529 ~~[26-60-102]~~ [26B-4-704](#).

1530 (c) "Telepsychiatric consultation" means a consultation between a physician and a
1531 board certified psychiatrist, both of whom are licensed to engage in the practice of medicine in
1532 the state, that utilizes:

1533 (i) the health records of the patient, provided from the patient or the referring
1534 physician;

1535 (ii) a written, evidence-based patient questionnaire; and

1536 (iii) telehealth services that meet industry security and privacy standards, including
1537 compliance with the:

1538 (A) Health Insurance Portability and Accountability Act; and

1539 (B) Health Information Technology for Economic and Clinical Health Act, Pub. L. No.
1540 111-5, 123 Stat. 226, 467, as amended.

- 1541 (2) This section applies to:
- 1542 (a) a managed care organization that contracts with the Medicaid program; and
- 1543 (b) a provider who is reimbursed for health care services under the Medicaid program.
- 1544 (3) The Medicaid program shall reimburse for telemedicine services at the same rate
- 1545 that the Medicaid program reimburses for other health care services.
- 1546 (4) The Medicaid program shall reimburse for telepsychiatric consultations at a rate set
- 1547 by the Medicaid program.

1548 Section 24. Section **26B-3-124**, which is renumbered from Section 26-18-15 is

1549 renumbered and amended to read:

1550 ~~[26-18-15]~~. **26B-3-124. Process to promote health insurance coverage for**

1551 **children.**

- 1552 (1) The department, in collaboration with the Department of Workforce Services and
- 1553 the State Board of Education, shall develop a process to promote health insurance coverage for
- 1554 a child in school when:
- 1555 (a) the child applies for free or reduced price school lunch;
- 1556 (b) a child enrolls in or registers in school; and
- 1557 (c) other appropriate school related opportunities.
- 1558 (2) The department, in collaboration with the Department of Workforce Services, shall
- 1559 promote and facilitate the enrollment of children identified under Subsection (1) without health
- 1560 insurance in the Utah Children's Health Insurance Program, the Medicaid program, or the Utah
- 1561 Premium Partnership for Health Insurance Program.

1562 Section 25. Section **26B-3-125**, which is renumbered from Section 26-18-16 is

1563 renumbered and amended to read:

1564 ~~[26-18-16]~~. **26B-3-125. Medicaid -- Continuous eligibility -- Promoting payment**

1565 **and delivery reform.**

- 1566 (1) In accordance with Subsection (2), and within appropriations from the Legislature,
- 1567 the department may amend the state Medicaid plan to:

1568 (a) create continuous eligibility for up to 12 months for an individual who has qualified
1569 for the state Medicaid program;

1570 (b) provide incentives in managed care contracts for an individual to obtain appropriate
1571 care in appropriate settings; and

1572 (c) require the managed care system to accept the risk of managing the Medicaid
1573 population assigned to the plan amendment in return for receiving the benefits of providing
1574 quality and cost effective care.

1575 (2) If the department amends the state Medicaid plan under Subsection (1)(a) or (b),
1576 the department:

1577 (a) shall ensure that the plan amendment:

1578 (i) is cost effective for the state Medicaid program;

1579 (ii) increases the quality and continuity of care for recipients; and

1580 (iii) calculates and transfers administrative savings from continuous enrollment from
1581 the Department of Workforce Services to the ~~[Department of Health]~~ department; and

1582 (b) may limit the plan amendment under Subsection (1)(a) or (b) to select geographic
1583 areas or specific Medicaid populations.

1584 (3) The department may seek approval for a state plan amendment, waiver, or a
1585 demonstration project from the Secretary of the United States Department of Health and
1586 Human Services if necessary to implement a plan amendment under Subsection (1)(a) or (b).

1587 Section 26. Section **26B-3-126**, which is renumbered from Section 26-18-17 is
1588 renumbered and amended to read:

1589 ~~[26-18-17]~~. **26B-3-126. Patient notice of health care provider privacy practices.**

1590 (1) (a) For purposes of this section:

1591 (i) "Health care provider" means a health care provider as defined in Section
1592 ~~78B-3-403~~ who:

1593 (A) receives payment for medical services from the Medicaid program established in
1594 this chapter, or the Children's Health Insurance Program established in ~~[Chapter 40, Utah~~

1595 ~~Children's Health Insurance Act]~~ Section 26B-3-902; and

1596 (B) submits a patient's personally identifiable information to the Medicaid eligibility
1597 database or the Children's Health Insurance Program eligibility database.

1598 (ii) "HIPAA" means 45 C.F.R. Parts 160, 162, and 164, Health Insurance Portability
1599 and Accountability Act of 1996, as amended.

1600 (b) Beginning July 1, 2013, this section applies to the Medicaid program, the
1601 Children's Health Insurance Program created in [~~Chapter 40, Utah Children's Health Insurance~~
1602 ~~Act]~~ Section 26B-3-902, and a health care provider.

1603 (2) A health care provider shall, as part of the notice of privacy practices required by
1604 HIPAA, provide notice to the patient or the patient's personal representative that the health care
1605 provider either has, or may submit, personally identifiable information about the patient to the
1606 Medicaid eligibility database and the Children's Health Insurance Program eligibility database.

1607 (3) The Medicaid program and the Children's Health Insurance Program may not give a
1608 health care provider access to the Medicaid eligibility database or the Children's Health
1609 Insurance Program eligibility database unless the health care provider's notice of privacy
1610 practices complies with Subsection (2).

1611 (4) The department may adopt an administrative rule to establish uniform language for
1612 the state requirement regarding notice of privacy practices to patients required under
1613 Subsection (2).

1614 Section 27. Section ~~26B-3-127~~, which is renumbered from Section 26-18-18 is
1615 renumbered and amended to read:

1616 ~~[26-18-18]~~. 26B-3-127. Optional Medicaid expansion.

1617 (1) The department and the governor may not expand the state's Medicaid program
1618 under PPACA unless:

1619 (a) the department expands Medicaid in accordance with Section [~~26-18-415~~]
1620 26B-3-210; or

1621 (b) (i) the governor or the governor's designee has reported the intention to expand the

1622 state Medicaid program under PPACA to the Legislature in compliance with the legislative
1623 review process in Section ~~[26-18-3]~~ [26B-3-108](#); and

1624 (ii) the governor submits the request for expansion of the Medicaid program for
1625 optional populations to the Legislature under the high impact federal funds request process
1626 required by Section [63J-5-204](#).

1627 (2) (a) The department shall request approval from CMS for waivers from federal
1628 statutory and regulatory law necessary to implement the health coverage improvement program
1629 under Section ~~[26-18-411]~~ [26B-3-207](#).

1630 (b) The health coverage improvement program under Section ~~[26-18-411]~~ [26B-3-207](#)
1631 is not subject to the requirements in Subsection (1).

1632 Section 28. Section **26B-3-128**, which is renumbered from Section 26-18-19 is
1633 renumbered and amended to read:

1634 ~~[26-18-19]~~. **26B-3-128. Medicaid vision services -- Request for proposals.**

1635 The department may select one or more contractors, in accordance with Title 63G,
1636 Chapter 6a, Utah Procurement Code, to provide vision services to the Medicaid populations
1637 that are eligible for vision services, as described in department rules, without restricting
1638 provider participation, and within existing appropriations from the Legislature.

1639 Section 29. Section **26B-3-129**, which is renumbered from Section 26-18-20 is
1640 renumbered and amended to read:

1641 ~~[26-18-20]~~. **26B-3-129. Review of claims -- Audit and investigation procedures.**

1642 (1) (a) The department shall adopt administrative rules in accordance with Title 63G,
1643 Chapter 3, Utah Administrative Rulemaking Act, and in consultation with providers and health
1644 care professionals subject to audit and investigation under the state Medicaid program, to
1645 establish procedures for audits and investigations that are fair and consistent with the duties of
1646 the department as the single state agency responsible for the administration of the Medicaid
1647 program under Section ~~[26-18-3]~~ [26B-3-108](#) and Title XIX of the Social Security Act.

1648 (b) If the providers and health care professionals do not agree with the rules proposed

1649 or adopted by the department under Subsection (1)(a), the providers or health care
1650 professionals may:

1651 (i) request a hearing for the proposed administrative rule or seek any other remedies
1652 under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
1653 (ii) request a review of the rule by the Legislature's Administrative Rules Review and
1654 General Oversight Committee created in Section [63G-3-501](#).

1655 (2) The department shall:

1656 (a) notify and educate providers and health care professionals subject to audit and
1657 investigation under the Medicaid program of the providers' and health care professionals'
1658 responsibilities and rights under the administrative rules adopted by the department under the
1659 provisions of this section;

1660 (b) ensure that the department, or any entity that contracts with the department to
1661 conduct audits:

1662 (i) has on staff or contracts with a medical or dental professional who is experienced in
1663 the treatment, billing, and coding procedures used by the type of provider being audited; and

1664 (ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if
1665 the provider who is the subject of the audit disputes the findings of the audit;

1666 (c) ensure that a finding of overpayment or underpayment to a provider is not based on
1667 extrapolation, as defined in Section [63A-13-102](#), unless:

1668 (i) there is a determination that the level of payment error involving the provider
1669 exceeds a 10% error rate:

1670 (A) for a sample of claims for a particular service code; and

1671 (B) over a three year period of time;

1672 (ii) documented education intervention has failed to correct the level of payment error;

1673 and

1674 (iii) the value of the claims for the provider, in aggregate, exceeds \$200,000 in
1675 reimbursement for a particular service code on an annual basis; and

1676 (d) require that any entity with which the office contracts, for the purpose of
1677 conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both
1678 overpayments and underpayments.

1679 (3) (a) If the department, or a contractor on behalf of the department:

1680 (i) intends to implement the use of extrapolation as a method of auditing claims, the
1681 department shall, prior to adopting the extrapolation method of auditing, report its intent to use
1682 extrapolation to the Social Services Appropriations Subcommittee; and

1683 (ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the
1684 department or the contractor may use extrapolation only for the service code associated with
1685 the findings under Subsections (2)(c)(i) through (iii).

1686 (b) (i) If extrapolation is used under this section, a provider may, at the provider's
1687 option, appeal the results of the audit based on:

1688 (A) each individual claim; or

1689 (B) the extrapolation sample.

1690 (ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G,
1691 General Government, Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid
1692 program and its manual or rules, or other laws or rules that may provide remedies to providers.

1693 Section 30. Section **26B-3-130**, which is renumbered from Section 26-18-21 is
1694 renumbered and amended to read:

1695 ~~[26-18-21]~~. **26B-3-130**. **Medicaid intergovernmental transfer report -- Approval**
1696 **requirements.**

1697 (1) As used in this section:

1698 (a) (i) "Intergovernmental transfer" means the transfer of public funds from:

1699 (A) a local government entity to another nonfederal governmental entity; or

1700 (B) from a nonfederal, government owned health care facility regulated under [~~Chapter~~
1701 ~~21, Health Care Facility Licensing and Inspection Act~~] Chapter 2, Part 2, Health Care Facility
1702 Licensing and Inspection, to another nonfederal governmental entity.

- 1703 (ii) "Intergovernmental transfer" does not include:
- 1704 (A) the transfer of public funds from one state agency to another state agency; or
- 1705 (B) a transfer of funds from the University of Utah Hospitals and Clinics.
- 1706 (b) (i) "Intergovernmental transfer program" means a federally approved
- 1707 reimbursement program or category that is authorized by the Medicaid state plan or waiver
- 1708 authority for intergovernmental transfers.
- 1709 (ii) "Intergovernmental transfer program" does not include the addition of a provider to
- 1710 an existing intergovernmental transfer program.
- 1711 (c) "Local government entity" means a county, city, town, special service district, local
- 1712 district, or local education agency as that term is defined in Section [63J-5-102](#).
- 1713 (d) "Non-state government entity" means a hospital authority, hospital district, health
- 1714 care district, special service district, county, or city.
- 1715 (2) (a) An entity that receives federal Medicaid dollars from the department as a result
- 1716 of an intergovernmental transfer shall, on or before August 1, 2017, and on or before August 1
- 1717 each year thereafter, provide the department with:
- 1718 (i) information regarding the payments funded with the intergovernmental transfer as
- 1719 authorized by and consistent with state and federal law;
- 1720 (ii) information regarding the entity's ability to repay federal funds, to the extent
- 1721 required by the department in the contract for the intergovernmental transfer; and
- 1722 (iii) other information reasonably related to the intergovernmental transfer that may be
- 1723 required by the department in the contract for the intergovernmental transfer.
- 1724 (b) On or before October 15, 2017, and on or before October 15 each subsequent year,
- 1725 the department shall prepare a report for the Executive Appropriations Committee that
- 1726 includes:
- 1727 (i) the amount of each intergovernmental transfer under Subsection (2)(a);
- 1728 (ii) a summary of changes to CMS regulations and practices that are known by the
- 1729 department regarding federal funds related to an intergovernmental transfer program; and

1730 (iii) other information the department gathers about the intergovernmental transfer
1731 under Subsection (2)(a).

1732 (3) The department shall not create a new intergovernmental transfer program after
1733 July 1, 2017, unless the department reports to the Executive Appropriations Committee, in
1734 accordance with Section 63J-5-206, before submitting the new intergovernmental transfer
1735 program for federal approval. The report shall include information required by Subsection
1736 63J-5-102(1)(d) and the analysis required in Subsections (2)(a) and (b).

1737 (4) (a) The department shall enter into new Nursing Care Facility Non-State
1738 Government-Owned Upper Payment Limit program contracts and contract amendments adding
1739 new nursing care facilities and new non-state government entity operators in accordance with
1740 this Subsection (4).

1741 (b) (i) If the nursing care facility expects to receive less than \$1,000,000 in federal
1742 funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment
1743 Limit program, excluding seed funding and administrative fees paid by the non-state
1744 government entity, the department shall enter into a Nursing Care Facility Non-State
1745 Government-Owned Upper Payment Limit program contract with the non-state government
1746 entity operator of the nursing care facility.

1747 (ii) If the nursing care facility expects to receive between \$1,000,000 and \$10,000,000
1748 in federal funds each year from the Nursing Care Facility Non-State Government-Owned
1749 Upper Payment Limit program, excluding seed funding and administrative fees paid by the
1750 non-state government entity, the department shall enter into a Nursing Care Facility Non-State
1751 Government-Owned Upper Payment Limit program contract with the non-state government
1752 entity operator of the nursing care facility after receiving the approval of the Executive
1753 Appropriations Committee.

1754 (iii) If the nursing care facility expects to receive more than \$10,000,000 in federal
1755 funds each year from the Nursing Care Facility Non-State Government-Owned Upper Payment
1756 Limit program, excluding seed funding and administrative fees paid by the non-state

1757 government entity, the department may not approve the application without obtaining approval
1758 from the Legislature and the governor.

1759 (c) A non-state government entity may not participate in the Nursing Care Facility
1760 Non-State Government-Owned Upper Payment Limit program unless the non-state government
1761 entity is a special service district, county, or city that operates a hospital or holds a license
1762 under [~~Chapter 21, Health Care Facility Licensing and Inspection Act~~] Chapter 2, Part 2,
1763 Health Care Facility Licensing and Inspection.

1764 (d) Each non-state government entity that participates in the Nursing Care Facility
1765 Non-State Government-Owned Upper Payment Limit program shall certify to the department
1766 that:

1767 (i) the non-state government entity is a local government entity that is able to make an
1768 intergovernmental transfer under applicable state and federal law;

1769 (ii) the non-state government entity has sufficient public funds or other permissible
1770 sources of seed funding that comply with the requirements in 42 C.F.R. Part 433, Subpart B;

1771 (iii) the funds received from the Nursing Care Facility Non-State Government-Owned
1772 Upper Payment Limit program are:

1773 (A) for each nursing care facility, available for patient care until the end of the
1774 non-state government entity's fiscal year; and

1775 (B) used exclusively for operating expenses for nursing care facility operations, patient
1776 care, capital expenses, rent, royalties, and other operating expenses; and

1777 (iv) the non-state government entity has completed all licensing, enrollment, and other
1778 forms and documents required by federal and state law to register a change of ownership with
1779 the department and with CMS.

1780 (5) The department shall add a nursing care facility to an existing Nursing Care Facility
1781 Non-State Government-Owned Upper Payment Limit program contract if:

1782 (a) the nursing care facility is managed by or affiliated with the same non-state
1783 government entity that also manages one or more nursing care facilities that are included in an

1784 existing Nursing Care Facility Non-State Government-Owned Upper Payment Limit program
1785 contract; and

1786 (b) the non-state government entity makes the certification described in Subsection
1787 (4)(d)(ii).

1788 (6) The department may not increase the percentage of the administrative fee paid by a
1789 non-state government entity to the department under the Nursing Care Facility Non-State
1790 Government-Owned Upper Payment Limit program.

1791 (7) The department may not condition participation in the Nursing Care Facility
1792 Non-State Government-Owned Upper Payment Limit program on:

1793 (a) a requirement that the department be allowed to direct or determine the types of
1794 patients that a non-state government entity will treat or the course of treatment for a patient in a
1795 non-state government nursing care facility; or

1796 (b) a requirement that a non-state government entity or nursing care facility post a
1797 bond, purchase insurance, or create a reserve account of any kind.

1798 (8) The non-state government entity shall have the primary responsibility for ensuring
1799 compliance with Subsection (4)(d)(ii).

1800 (9) (a) The department may not enter into a new Nursing Care Facility Non-State
1801 Government-Owned Upper Payment Limit program contract before January 1, 2019.

1802 (b) Subsection (9)(a) does not apply to:

1803 (i) a new Nursing Care Facility Non-State Government-Owned Upper Payment Limit
1804 program contract that was included in the federal funds request summary under Section
1805 [63J-5-201](#) for fiscal year 2018; or

1806 (ii) a nursing care facility that is operated or managed by the same company as a
1807 nursing care facility that was included in the federal funds request summary under Section
1808 [63J-5-201](#) for fiscal year 2018.

1809 Section 31. Section **26B-3-131**, which is renumbered from Section 26-18-22 is
1810 renumbered and amended to read:

1811 ~~[26-18-22]~~. **26B-3-131. Screening, Brief Intervention, and Referral to**
1812 **Treatment Medicaid reimbursement.**

1813 (1) As used in this section:

1814 (a) "Controlled substance prescriber" means a controlled substance prescriber, as that
1815 term is defined in Section 58-37-6.5, who:

1816 (i) has a record of having completed SBIRT training, in accordance with Subsection
1817 58-37-6.5(2), before providing the SBIRT services; and

1818 (ii) is a Medicaid enrolled health care provider.

1819 (b) "SBIRT" means the same as that term is defined in Section 58-37-6.5.

1820 (2) The department shall reimburse a controlled substance prescriber who provides
1821 SBIRT services to a Medicaid enrollee who is 13 years ~~[of age]~~ old or older for the SBIRT
1822 services.

1823 Section 32. Section **26B-3-132**, which is renumbered from Section 26-18-23 is
1824 renumbered and amended to read:

1825 ~~[26-18-23]~~. **26B-3-132. Prescribing policies for opioid prescriptions.**

1826 (1) The department may implement a prescribing policy for certain opioid prescriptions
1827 that is substantially similar to the prescribing policies required in Section 31A-22-615.5.

1828 (2) The department may amend the state program and apply for waivers for the state
1829 program, if necessary, to implement Subsection (1).

1830 Section 33. Section **26B-3-133**, which is renumbered from Section 26-18-24 is
1831 renumbered and amended to read:

1832 ~~[26-18-24]~~. **26B-3-133. Reimbursement for long-acting reversible contraception**
1833 **immediately following childbirth.**

1834 (1) As used in this section, "long-acting reversible contraception" means a
1835 contraception method that requires administration less than once per month, including:

1836 (a) an intrauterine device; and

1837 (b) a contraceptive implant.

1838 (2) The division shall separately identify and reimburse, from other labor and delivery
1839 services within the Medicaid program, the provision and insertion of long-acting reversible
1840 contraception immediately after childbirth.

1841 Section 34. Section **26B-3-134**, which is renumbered from Section 26-18-25 is
1842 renumbered and amended to read:

1843 ~~[26-18-25]~~. **26B-3-134**. **Coverage of exome sequence testing.**

1844 (1) As used in this section, "exome sequence testing" means a genomic technique for
1845 sequencing the genome of an individual for diagnostic purposes.

1846 (2) The Medicaid program shall reimburse for exome sequence testing:

1847 (a) for an enrollee who:

1848 (i) is younger than 21 years ~~[of age]~~ old; and

1849 (ii) who remains undiagnosed after exhausting all other appropriate diagnostic-related
1850 tests;

1851 (b) performed by a nationally recognized provider with significant experience in exome
1852 sequence testing;

1853 (c) that is medically necessary; and

1854 (d) at a rate set by the Medicaid program.

1855 Section 35. Section **26B-3-135**, which is renumbered from Section 26-18-26 is
1856 renumbered and amended to read:

1857 ~~[26-18-26]~~. **26B-3-135**. **Reimbursement for nonemergency secured behavioral**
1858 **health transport providers.**

1859 The department may not reimburse a nonemergency secured behavioral health transport
1860 provider that is designated under Section ~~[26-8a-303]~~ 26B-4-117.

1861 Section 36. Section **26B-3-136**, which is renumbered from Section 26-18-27 is
1862 renumbered and amended to read:

1863 ~~[26-18-27]~~. **26B-3-136**. **Children's Health Care Coverage Program.**

1864 (1) As used in this section:

- 1865 (a) "CHIP" means the Children's Health Insurance Program created in Section
1866 ~~[26-40-103]~~ [26B-3-902](#).
- 1867 (b) "Program" means the Children's Health Care Coverage Program created in
1868 Subsection (2).
- 1869 (2) (a) There is created the Children's Health Care Coverage Program within the
1870 department.
- 1871 (b) The purpose of the program is to:
- 1872 (i) promote health insurance coverage for children in accordance with Section
1873 ~~[26-18-15]~~ [26B-3-124](#);
- 1874 (ii) conduct research regarding families who are eligible for Medicaid and CHIP to
1875 determine awareness and understanding of available coverage;
- 1876 (iii) analyze trends in disenrollment and identify reasons that families may not be
1877 renewing enrollment, including any barriers in the process of renewing enrollment;
- 1878 (iv) administer surveys to recently enrolled CHIP and children's Medicaid enrollees to
1879 identify:
- 1880 (A) how the enrollees learned about coverage; and
- 1881 (B) any barriers during the application process;
- 1882 (v) develop promotional material regarding CHIP and children's Medicaid eligibility,
1883 including outreach through social media, video production, and other media platforms;
- 1884 (vi) identify ways that the eligibility website for enrollment in CHIP and children's
1885 Medicaid can be redesigned to increase accessibility and enhance the user experience;
- 1886 (vii) identify outreach opportunities, including partnerships with community
1887 organizations including:
- 1888 (A) schools;
- 1889 (B) small businesses;
- 1890 (C) unemployment centers;
- 1891 (D) parent-teacher associations; and

1892 (E) youth athlete clubs and associations; and
1893 (viii) develop messaging to increase awareness of coverage options that are available
1894 through the department.

1895 (3) (a) The department may not delegate implementation of the program to a private
1896 entity.

1897 (b) Notwithstanding Subsection (3)(a), the department may contract with a media
1898 agency to conduct the activities described in Subsection (2)(b)(iv) and (vii).

1899 Section 37. Section **26B-3-137**, which is renumbered from Section 26-18-28 is
1900 renumbered and amended to read:

1901 ~~[26-18-28]~~. **26B-3-137. Reimbursement for diabetes prevention program.**

1902 (1) As used in this section, "DPP" means the National Diabetes Prevention Program
1903 developed by the United States Centers for Disease Control and Prevention.

1904 (2) Beginning July 1, 2022, the Medicaid program shall reimburse a provider for an
1905 enrollee's participation in the DPP if the enrollee:

1906 (a) meets the DPP's eligibility requirements; and

1907 (b) has not previously participated in the DPP after July 1, 2022, while enrolled in the
1908 Medicaid program.

1909 (3) Subject to appropriation, the Medicaid program may set the rate for reimbursement.

1910 (4) The department may apply for a state plan amendment if necessary to implement
1911 this section.

1912 (5) (a) On or after July 1, 2025, but before October 1, 2025, the department shall
1913 provide a written report regarding the efficacy of the DPP and reimbursement under this
1914 section to the Health and Human Services Interim Committee.

1915 (b) The report described in Subsection (5)(a) shall include:

1916 (i) the total number of enrollees with a prediabetic condition as of July 1, 2022;

1917 (ii) the total number of enrollees as of July 1, 2022, with a diagnosis of type 2 diabetes;

1918 (iii) the total number of enrollees who participated in the DPP;

- 1919 (iv) the total cost incurred by the state to implement this section; and
- 1920 (v) any conclusions that can be drawn regarding the impact of the DPP on the rate of
- 1921 type 2 diabetes for enrollees.

1922 Section 38. Section **26B-3-138**, which is renumbered from Section 26-18-427 is

1923 renumbered and amended to read:

1924 ~~[26-18-427]~~. **26B-3-138. Behavioral health delivery working group.**

1925 (1) As used in this section, "targeted adult Medicaid program" means the same as that

1926 term is defined in Section ~~[26-18-411]~~ [26B-3-207](#).

1927 (2) On or before May 31, 2022, the department shall convene a working group to

1928 collaborate with the department on:

1929 (a) establishing specific and measurable metrics regarding:

1930 (i) compliance of managed care organizations in the state with federal Medicaid

1931 managed care requirements;

1932 (ii) timeliness and accuracy of authorization and claims processing in accordance with

1933 Medicaid policy and contract requirements;

1934 (iii) reimbursement by managed care organizations in the state to providers to maintain

1935 adequacy of access to care;

1936 (iv) availability of care management services to meet the needs of Medicaid-eligible

1937 individuals enrolled in the plans of managed care organizations in the state; and

1938 (v) timeliness of resolution for disputes between a managed care organization and the

1939 managed care organization's providers and enrollees;

1940 (b) improving the delivery of behavioral health services in the Medicaid program;

1941 (c) proposals to implement the delivery system adjustments authorized under

1942 Subsection ~~[26-18-428]~~ [26B-3-223](#)(3); and

1943 (d) issues that are identified by managed care organizations, behavioral health service

1944 providers, and the department.

1945 (3) The working group convened under Subsection (2) shall:

- 1946 (a) meet quarterly; and
- 1947 (b) consist of at least the following individuals:
- 1948 (i) the executive director or the executive director's designee;
- 1949 (ii) for each Medicaid accountable care organization with which the department
- 1950 contracts, an individual selected by the accountable care organization;
- 1951 (iii) five individuals selected by the department to represent various types of behavioral
- 1952 health services providers, including, at a minimum, individuals who represent providers who
- 1953 provide the following types of services:
- 1954 (A) acute inpatient behavioral health treatment;
- 1955 (B) residential treatment;
- 1956 (C) intensive outpatient or partial hospitalization treatment; and
- 1957 (D) general outpatient treatment;
- 1958 (iv) a representative of an association that represents behavioral health treatment
- 1959 providers in the state, designated by the Utah Behavioral Healthcare Council convened by the
- 1960 Utah Association of Counties;
- 1961 (v) a representative of an organization representing behavioral health organizations;
- 1962 (vi) the chair of the Utah Substance Use and Mental Health Advisory Council created
- 1963 in Section [63M-7-301](#);
- 1964 (vii) a representative of an association that represents local authorities who provide
- 1965 public behavioral health care, designated by the department;
- 1966 (viii) one member of the Senate, appointed by the president of the Senate; and
- 1967 (ix) one member of the House of Representatives, appointed by the speaker of the
- 1968 House of Representatives.
- 1969 (4) The working group convened under this section shall recommend to the
- 1970 department:
- 1971 (a) specific and measurable metrics under Subsection (2)(a);
- 1972 (b) how physical and behavioral health services may be integrated for the targeted adult

1973 Medicaid program, including ways the department may address issues regarding:
1974 (i) filing of claims;
1975 (ii) authorization and reauthorization for treatment services;
1976 (iii) reimbursement rates; and
1977 (iv) other issues identified by the department, behavioral health services providers, or
1978 Medicaid managed care organizations;

1979 (c) ways to improve delivery of behavioral health services to enrollees, including
1980 changes to statute or administrative rule; and
1981 (d) wraparound service coverage for enrollees who need specific, nonclinical services
1982 to ensure a path to success.

1983 Section 39. Section **26B-3-139**, which is renumbered from Section 26-18-603 is
1984 renumbered and amended to read:

1985 ~~[26-18-603]~~. **26B-3-139. Adjudicative proceedings related to Medicaid**
1986 **funds.**

1987 (1) If a proceeding of the department, under Title 63G, Chapter 4, Administrative
1988 Procedures Act, relates in any way to recovery of Medicaid funds:

1989 (a) the presiding officer shall be designated by the executive director of the department
1990 and report directly to the executive director or, in the discretion of the executive director, report
1991 directly to the director of the Office of Internal Audit; and

1992 (b) the decision of the presiding officer is the recommended decision to the executive
1993 director of the department or a designee of the executive director who is not in the division.

1994 (2) Subsection (1) does not apply to hearings conducted by the Department of
1995 Workforce Services relating to medical assistance eligibility determinations.

1996 (3) If a proceeding of the department, under Title 63G, Chapter 4, Administrative
1997 Procedures Act, relates in any way to Medicaid or Medicaid funds, the following may attend
1998 and present evidence or testimony at the proceeding:

1999 (a) the director of the Office of Internal Audit, or the director's designee; and

2000 (b) the inspector general of Medicaid services or the inspector general's designee.

2001 (4) In relation to a proceeding of the department under Title 63G, Chapter 4,
2002 Administrative Procedures Act, a person may not, outside of the actual proceeding, attempt to
2003 influence the decision of the presiding officer.

2004 Section 40. Section **26B-3-140**, which is renumbered from Section 26-18-604 is
2005 renumbered and amended to read:

2006 ~~[26-18-604]~~. **26B-3-140**. **Medical assistance accountability -- Division**
2007 **duties -- Reporting.**

2008 (1) As used in this section:

2009 (a) "Abuse" means:

2010 (i) an action or practice that:

2011 (A) is inconsistent with sound fiscal, business, or medical practices; and

2012 (B) results, or may result, in unnecessary Medicaid related costs or other medical or
2013 hospital assistance costs; or

2014 (ii) reckless or negligent upcoding.

2015 (b) "Fraud" means intentional or knowing:

2016 (i) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs,
2017 claims, reimbursement, or practice; or

2018 (ii) deception or misrepresentation in relation to medical or hospital assistance funds,
2019 costs, claims, reimbursement, or practice.

2020 (c) "Upcoding" means assigning an inaccurate billing code for a service that is payable
2021 or reimbursable by Medicaid funds, if the correct billing code for the service, taking into
2022 account reasonable opinions derived from official published coding definitions, would result in
2023 a lower Medicaid payment or reimbursement.

2024 (d) "Waste" means overutilization of resources or inappropriate payment.

2025 (2) The division shall:

2026 [(+)] (a) develop and implement procedures relating to Medicaid funds and medical or

2027 hospital assistance funds to ensure that providers do not receive:

2028 ~~[(a)]~~ (i) duplicate payments for the same goods or services;

2029 ~~[(b)]~~ (ii) payment for goods or services by resubmitting a claim for which:

2030 ~~[(i)]~~ (A) payment has been disallowed on the grounds that payment would be a

2031 violation of federal or state law, administrative rule, or the state plan; and

2032 ~~[(ii)]~~ (B) the decision to disallow the payment has become final;

2033 ~~[(e)]~~ (iii) payment for goods or services provided after a recipient's death, including

2034 payment for pharmaceuticals or long-term care; or

2035 ~~[(d)]~~ (iv) payment for transporting an unborn infant;

2036 ~~[(2)]~~ (b) consult with ~~[the Centers for Medicaid and Medicare Services]~~ CMS, other

2037 states, and the Office of Inspector General of Medicaid Services to determine and implement

2038 best practices for discovering and eliminating fraud, waste, and abuse of Medicaid funds and

2039 medical or hospital assistance funds;

2040 ~~[(3)]~~ (c) actively seek repayment from providers for improperly used or paid:

2041 ~~[(a)]~~ (i) Medicaid funds; and

2042 ~~[(b)]~~ (ii) medical or hospital assistance funds;

2043 ~~[(4)]~~ (d) coordinate, track, and keep records of all division efforts to obtain repayment

2044 of the funds described in Subsection ~~[(3)]~~ (2)(c), and the results of those efforts;

2045 ~~[(5)]~~ (e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to

2046 obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the

2047 pharmaceuticals that represent the highest 45% of state Medicaid expenditures for

2048 pharmaceuticals and on an annual basis for the remaining pharmaceuticals:

2049 ~~[(a)]~~ (i) tracking changes in the price of pharmaceuticals;

2050 ~~[(b)]~~ (ii) checking the availability and price of generic drugs;

2051 ~~[(e)]~~ (iii) reviewing and updating the state's maximum allowable cost list; and

2052 ~~[(d)]~~ (iv) comparing pharmaceutical costs of the state Medicaid program to available

2053 pharmacy price lists; and

2054 [(6)] (f) provide training, on an annual basis, to the employees of the division who
 2055 make decisions on billing codes, or who are in the best position to observe and identify
 2056 upcoding, in order to avoid and detect upcoding.

2057 Section 41. Section **26B-3-141**, which is renumbered from Section 26-18-703 is
 2058 renumbered and amended to read:

2059 ~~[26-18-703].~~ **26B-3-141. Medical assistance from division or Department**
 2060 **of Workforce Services and compliance under adoption assistance interstate compact --**
 2061 **Penalty for fraudulent claim.**

2062 (1) As used in this section:

2063 (a) "Adoption assistance" means the same as that term is defined in Section [80-2-809](#).

2064 (b) "Adoption assistance agreement" means the same as that term is defined in Section
 2065 [80-2-809](#).

2066 (c) "Adoption assistance interstate compact" means an agreement executed by the
 2067 Division of Child and Family Services with any other state in accordance with Section
 2068 [80-2-809](#).

2069 [(1)] (2) (a) A child who is a resident of this state and is the subject of an adoption
 2070 assistance interstate compact is entitled to receive medical assistance from the division and the
 2071 Department of Workforce Services by filing a certified copy of the child's adoption assistance
 2072 agreement with the division or the Department of Workforce Services.

2073 (b) The adoptive parent of the child described in Subsection [(1)] (2)(a) shall annually
 2074 provide the division or the Department of Workforce Services with evidence verifying that the
 2075 adoption assistance agreement is still effective.

2076 [(2)] (3) The Department of Workforce Services shall consider the recipient of medical
 2077 assistance under this section as the Department of Workforce Services does any other recipient
 2078 of medical assistance under an adoption assistance agreement executed by the Division of
 2079 Child and Family Services.

2080 [(3)] (4) (a) A person may not submit a claim for payment or reimbursement under this

2081 section that the person knows is false, misleading, or fraudulent.

2082 (b) A violation of Subsection ~~[(3)]~~ (4)(a) is a third degree felony.

2083 (5) The division and the Department of Workforce Services shall:

2084 (a) cooperate with the Division of Child and Family Services in regard to an adoption
2085 assistance interstate compact; and

2086 (b) comply with an adoption assistance interstate compact.

2087 Section 42. Section **26B-3-201**, which is renumbered from Section 26-18-403 is
2088 renumbered and amended to read:

2089 **Part 2. Medicaid Waivers**

2090 ~~[26-18-403].~~ **26B-3-201. Medicaid waiver for independent foster care**
2091 **adolescents.**

2092 (1) ~~[For purposes of]~~ As used in this section, an "independent foster care adolescent"
2093 includes any individual who reached 18 years ~~[of age]~~ old while in the custody of the ~~[Division~~
2094 ~~of Child and Family Services, or the Department of Human Services]~~ department if the
2095 ~~[Division of Child and Family Services]~~ department was the primary case manager, or a
2096 federally recognized Indian tribe.

2097 (2) An independent foster care adolescent is eligible, when funds are available, for
2098 Medicaid coverage until the individual reaches 21 years ~~[of age]~~ old.

2099 (3) Before July 1, 2006, the division shall submit a state Medicaid Plan amendment to
2100 ~~[the Center For Medicaid Services]~~ CMS to provide medical coverage for independent foster
2101 care adolescents effective fiscal year 2006-07.

2102 Section 43. Section **26B-3-202**, which is renumbered from Section 26-18-405 is
2103 renumbered and amended to read:

2104 ~~[26-18-405].~~ **26B-3-202. Waivers to maximize replacement of**
2105 **fee-for-service delivery model -- Cost of mandated program changes.**

2106 (1) The department shall develop a waiver program in the Medicaid program to replace
2107 the fee-for-service delivery model with one or more risk-based delivery models.

- 2108 (2) The waiver program shall:
- 2109 (a) restructure the program's provider payment provisions to reward health care
2110 providers for delivering the most appropriate services at the lowest cost and in ways that,
2111 compared to services delivered before implementation of the waiver program, maintain or
2112 improve recipient health status;
- 2113 (b) restructure the program's cost sharing provisions and other incentives to reward
2114 recipients for personal efforts to:
- 2115 (i) maintain or improve their health status; and
2116 (ii) use providers that deliver the most appropriate services at the lowest cost;
- 2117 (c) identify the evidence-based practices and measures, risk adjustment methodologies,
2118 payment systems, funding sources, and other mechanisms necessary to reward providers for
2119 delivering the most appropriate services at the lowest cost, including mechanisms that:
- 2120 (i) pay providers for packages of services delivered over entire episodes of illness
2121 rather than for individual services delivered during each patient encounter; and
2122 (ii) reward providers for delivering services that make the most positive contribution to
2123 a recipient's health status;
- 2124 (d) limit total annual per-patient-per-month expenditures for services delivered through
2125 fee-for-service arrangements to total annual per-patient-per-month expenditures for services
2126 delivered through risk-based arrangements covering similar recipient populations and services;
2127 and
- 2128 (e) except as provided in Subsection (4), limit the rate of growth in
2129 per-patient-per-month General Fund expenditures for the program to the rate of growth in
2130 General Fund expenditures for all other programs, when the rate of growth in the General Fund
2131 expenditures for all other programs is greater than zero.
- 2132 (3) To the extent possible, the department shall operate the waiver program with the
2133 input of stakeholder groups representing those who will be affected by the waiver program.
- 2134 (4) (a) For purposes of this Subsection (4), "mandated program change" shall be

2135 determined by the department in consultation with the Medicaid accountable care
2136 organizations, and may include a change to the state Medicaid program that is required by state
2137 or federal law, state or federal guidance, policy, or the state Medicaid plan.

2138 (b) A mandated program change shall be included in the base budget for the Medicaid
2139 program for the fiscal year in which the Medicaid program adopted the mandated program
2140 change.

2141 (c) The mandated program change is not subject to the limit on the rate of growth in
2142 per-patient-per-month General Fund expenditures for the program established in Subsection
2143 (2)(e), until the fiscal year following the fiscal year in which the Medicaid program adopted the
2144 mandated program change.

2145 (5) A managed care organization or a pharmacy benefit manager that provides a
2146 pharmacy benefit to an enrollee shall establish a unique group number, payment classification
2147 number, or bank identification number for each Medicaid managed care organization plan for
2148 which the managed care organization or pharmacy benefit manager provides a pharmacy
2149 benefit.

2150 Section 44. Section **26B-3-203**, which is renumbered from Section 26-18-405.5 is
2151 renumbered and amended to read:

2152 ~~[26-18-405.5].~~ **26B-3-203. Base budget appropriations for Medicaid**
2153 **accountable care organizations and behavioral health plans -- Forecast of behavioral**
2154 **health services cost.**

2155 (1) As used in this section:

2156 (a) "ACO" means an accountable care organization that contracts with the state's
2157 Medicaid program for:

- 2158 (i) physical health services; or
- 2159 (ii) integrated physical and behavioral health services.

2160 (b) "Base budget" means the same as that term is defined in legislative rule.

2161 (c) "Behavioral health plan" means a managed care or fee for service delivery system

2162 that contracts with or is operated by the department to provide behavioral health services to
2163 Medicaid eligible individuals.

2164 (d) "Behavioral health services" means mental health or substance use treatment or
2165 services.

2166 (e) "General Fund growth factor" means the amount determined by dividing the next
2167 fiscal year ongoing General Fund revenue estimate by current fiscal year ongoing
2168 appropriations from the General Fund.

2169 (f) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal
2170 year ongoing General Fund revenue estimate identified by the Executive Appropriations
2171 Committee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal
2172 Analyst in preparing budget recommendations.

2173 (g) "PMPM" means per-member-per-month funding.

2174 (2) If the General Fund growth factor is less than 100%, the next fiscal year base
2175 budget shall, subject to Subsection (5), include an appropriation to the department in an
2176 amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health
2177 plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied
2178 by 100%.

2179 (3) If the General Fund growth factor is greater than or equal to 100%, but less than
2180 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation
2181 to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs
2182 and behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral
2183 health plans multiplied by the General Fund growth factor.

2184 (4) If the General Fund growth factor is greater than or equal to 102%, the next fiscal
2185 year base budget shall, subject to Subsection (5), include an appropriation to the department in
2186 an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health
2187 plans is greater than or equal to the current fiscal year PMPM for the ACOs and behavioral
2188 health plans multiplied by 102% and less than or equal to the current fiscal year PMPM for the

2189 ACOs and behavioral health plans multiplied by the General Fund growth factor.

2190 (5) The appropriations provided to the department for behavioral health plans under
2191 this section shall be reduced by the amount contributed by counties in the current fiscal year for
2192 behavioral health plans in accordance with Subsections [17-43-201\(5\)\(k\)](#) and
2193 [17-43-301\(6\)\(a\)\(x\)](#).

2194 (6) In order for the department to estimate the impact of Subsections (2) through (4)
2195 before identification of the next fiscal year ongoing General Fund revenue estimate, the
2196 Governor's Office of Planning and Budget shall, in cooperation with the Office of the
2197 Legislative Fiscal Analyst, develop an estimate of ongoing General Fund revenue for the next
2198 fiscal year and provide the estimate to the department no later than November 1 of each year.

2199 (7) The Office of the Legislative Fiscal Analyst shall include an estimate of the cost of
2200 behavioral health services in any state Medicaid funding or savings forecast that is completed
2201 in coordination with the department and the Governor's Office of Planning and Budget.

2202 Section 45. Section **26B-3-204**, which is renumbered from Section 26-18-408 is
2203 renumbered and amended to read:

2204 ~~[26-18-408]~~. **26B-3-204. Incentives to appropriately use emergency**
2205 **department services.**

2206 (1) (a) This section applies to the Medicaid program and to the Utah Children's Health
2207 Insurance Program created in [~~Chapter 40, Utah Children's Health Insurance Act~~] Section
2208 [26B-3-902](#).

2209 (b) As used in this section:

2210 (i) "Managed care organization" means a comprehensive full risk managed care
2211 delivery system that contracts with the Medicaid program or the Children's Health Insurance
2212 Program to deliver health care through a managed care plan.

2213 (ii) "Managed care plan" means a risk-based delivery service model authorized by
2214 Section [~~26-18-405~~] [26B-3-202](#) and administered by a managed care organization.

2215 (iii) "Non-emergent care":

2216 (A) means use of the emergency department to receive health care that is non-emergent
2217 as defined by the department by administrative rule adopted in accordance with Title 63G,
2218 Chapter 3, Utah Administrative Rulemaking Act, and the Emergency Medical Treatment and
2219 Active Labor Act; and

2220 (B) does not mean the medical services provided to an individual required by the
2221 Emergency Medical Treatment and Active Labor Act, including services to conduct a medical
2222 screening examination to determine if the recipient has an emergent or non-emergent condition.

2223 (iv) "Professional compensation" means payment made for services rendered to a
2224 Medicaid recipient by an individual licensed to provide health care services.

2225 (v) "Super-utilizer" means a Medicaid recipient who has been identified by the
2226 recipient's managed care organization as a person who uses the emergency department
2227 excessively, as defined by the managed care organization.

2228 (2) (a) A managed care organization may, in accordance with Subsections (2)(b) and
2229 (c):

2230 (i) audit emergency department services provided to a recipient enrolled in the
2231 managed care plan to determine if non-emergent care was provided to the recipient; and

2232 (ii) establish differential payment for emergent and non-emergent care provided in an
2233 emergency department.

2234 (b) (i) The differential payments under Subsection (2)(a)(ii) do not apply to
2235 professional compensation for services rendered in an emergency department.

2236 (ii) Except in cases of suspected fraud, waste, and abuse, a managed care organization's
2237 audit of payment under Subsection (2)(a)(i) is limited to the 18-month period of time after the
2238 date on which the medical services were provided to the recipient. If fraud, waste, or abuse is
2239 alleged, the managed care organization's audit of payment under Subsection (2)(a)(i) is limited
2240 to three years after the date on which the medical services were provided to the recipient.

2241 (c) The audits and differential payments under Subsections (2)(a) and (b) apply to
2242 services provided to a recipient on or after July 1, 2015.

2243 (3) A managed care organization shall:
2244 (a) use the savings under Subsection (2) to maintain and improve access to primary
2245 care and urgent care services for all Medicaid or CHIP recipients enrolled in the managed care
2246 plan;
2247 (b) provide viable alternatives for increasing primary care provider reimbursement
2248 rates to incentivize after hours primary care access for recipients; and
2249 (c) report to the department on how the managed care organization complied with this
2250 Subsection (3).
2251 (4) The department may:
2252 (a) through administrative rule adopted by the department, develop quality
2253 measurements that evaluate a managed care organization's delivery of:
2254 (i) appropriate emergency department services to recipients enrolled in the managed
2255 care plan;
2256 (ii) expanded primary care and urgent care for recipients enrolled in the managed care
2257 plan, with consideration of the managed care organization's:
2258 (A) delivery of primary care, urgent care, and after hours care through means other than
2259 the emergency department;
2260 (B) recipient access to primary care providers and community health centers including
2261 evening and weekend access; and
2262 (C) other innovations for expanding access to primary care; and
2263 (iii) quality of care for the managed care plan members;
2264 (b) compare the quality measures developed under Subsection (4)(a) for each managed
2265 care organization; and
2266 (c) develop, by administrative rule, an algorithm to determine assignment of new,
2267 unassigned recipients to specific managed care plans based on the plan's performance in
2268 relation to the quality measures developed pursuant to Subsection (4)(a).
2269 Section 46. Section **26B-3-205**, which is renumbered from Section 26-18-409 is

2270 renumbered and amended to read:

2271 ~~[26-18-409]~~. **26B-3-205. Long-term care insurance partnership.**

2272 (1) As used in this section:

2273 (a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec.

2274 7702B(b).

2275 (b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec.

2276 1396p(b)(1)(C)(iii).

2277 (c) "State plan amendment" means an amendment to the state Medicaid plan drafted by
2278 the department in compliance with this section.

2279 (2) No later than July 1, 2014, the department shall seek federal approval of a state plan
2280 amendment that creates a qualified long-term care insurance partnership.

2281 (3) The department may make rules to comply with federal laws and regulations
2282 relating to qualified long-term care insurance partnerships and qualified long-term care
2283 insurance contracts.

2284 Section 47. Section **26B-3-206**, which is renumbered from Section 26-18-410 is
2285 renumbered and amended to read:

2286 ~~[26-18-410]~~. **26B-3-206. Medicaid waiver for children with disabilities**
2287 **and complex medical needs.**

2288 (1) As used in this section:

2289 (a) "Additional eligibility criteria" means the additional eligibility criteria set by the
2290 department under Subsection (4)(e).

2291 (b) "Complex medical condition" means a physical condition of an individual that:

2292 (i) results in severe functional limitations for the individual; and

2293 (ii) is likely to:

2294 (A) last at least 12 months; or

2295 (B) result in death.

2296 (c) "Program" means the program for children with complex medical conditions

2297 created in Subsection (3).

2298 (d) "Qualified child" means a child who:

2299 (i) is less than 19 years old;

2300 (ii) is diagnosed with a complex medical condition;

2301 (iii) has a condition that meets the definition of disability in 42 U.S.C. Sec. 12102; and

2302 (iv) meets the additional eligibility criteria.

2303 (2) The department shall apply for a Medicaid home and community-based waiver with
2304 CMS to implement, within the state Medicaid program, the program described in Subsection
2305 (3).

2306 (3) If the waiver described in Subsection (2) is approved, the department shall offer a
2307 program that:

2308 (a) as funding permits, provides treatment for qualified children;

2309 (b) if approved by CMS and as funding permits, beginning in fiscal year 2023 provides
2310 on an ongoing basis treatment for 130 more qualified children than the program provided
2311 treatment for during fiscal year 2022; ~~and~~

2312 (c) accepts applications for the program on an ongoing basis~~[-]~~;

2313 ~~[(†)]~~ (d) requires periodic reevaluations of an enrolled child's eligibility and other
2314 applicants or eligible children waiting for services in the program based on the additional
2315 eligibility criteria; and

2316 ~~[(†)]~~ (e) at the time of reevaluation, allows the department to disenroll a child based on
2317 the prioritization described in Subsection (4)(a) and additional eligibility criteria.

2318 (4) The department shall:

2319 (a) establish by rule made in accordance with Title 63G, Chapter 3, Utah

2320 Administrative Rulemaking Act, criteria to prioritize qualified children's participation in the
2321 program based on the following factors, in the following priority order:

2322 (i) the complexity of a qualified child's medical condition; and

2323 (ii) the financial needs of the qualified child and the qualified child's family;

2324 (b) convene a public process to determine the benefits and services to offer a qualified
2325 child under the program;

2326 (c) evaluate, on an ongoing basis, the cost and effectiveness of the program;

2327 (d) if funding for the program is reduced, develop an evaluation process to reduce the
2328 number of children served based on the participation criteria established under Subsection
2329 (4)(a); and

2330 (e) establish, by rule made in accordance with Title 63G, Chapter 3, Utah
2331 Administrative Rulemaking Act, additional eligibility criteria based on the factors described in
2332 Subsections (4)(a)(i) and (ii).

2333 Section 48. Section **26B-3-207**, which is renumbered from Section 26-18-411 is
2334 renumbered and amended to read:

2335 ~~[26-18-411]~~. **26B-3-207. Health coverage improvement program --**
2336 **Eligibility -- Annual report -- Expansion of eligibility for adults with dependent children.**

2337 (1) As used in this section:

2338 (a) "Adult in the expansion population" means an individual who:

2339 (i) is described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and

2340 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
2341 individual.

2342 (b) "Enhancement waiver program" means the Primary Care Network enhancement
2343 waiver program described in Section ~~[26-18-416]~~ 26B-3-211.

2344 (c) "Federal poverty level" means the poverty guidelines established by the Secretary of
2345 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).

2346 (d) "Health coverage improvement program" means the health coverage improvement
2347 program described in Subsections (3) through ~~[(10)]~~ (9).

2348 (e) "Homeless":

2349 (i) means an individual who is chronically homeless, as determined by the department;

2350 and

- 2351 (ii) includes someone who was chronically homeless and is currently living in
2352 supported housing for the chronically homeless.
- 2353 (f) "Income eligibility ceiling" means the percent of federal poverty level:
2354 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
2355 Chapter 1, Budgetary Procedures Act; and
2356 (ii) under which an individual may qualify for Medicaid coverage in accordance with
2357 this section.
- 2358 (g) "Targeted adult Medicaid program" means the program implemented by the
2359 department under Subsections (5) through (7).
- 2360 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
2361 allow temporary residential treatment for substance [~~abuse~~] use, for the traditional Medicaid
2362 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that
2363 provides rehabilitation services that are medically necessary and in accordance with an
2364 individualized treatment plan, as approved by CMS and as long as the county makes the
2365 required match under Section [17-43-201](#).
- 2366 (3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
2367 increase the income eligibility ceiling to a percentage of the federal poverty level designated by
2368 the department, based on appropriations for the program, for an individual with a dependent
2369 child.
- 2370 (4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an
2371 amendment of existing waivers, from federal statutory and regulatory law necessary for the
2372 state to implement the health coverage improvement program in the Medicaid program in
2373 accordance with this section.
- 2374 (5) (a) An adult in the expansion population is eligible for Medicaid if the adult meets
2375 the income eligibility and other criteria established under Subsection (6).
- 2376 (b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:
2377 (i) through the traditional fee for service Medicaid model in counties without Medicaid

2378 accountable care organizations or the state's Medicaid accountable care organization delivery
2379 system, where implemented and subject to Section [~~26-18-428~~] [26B-3-223](#);

2380 (ii) except as provided in Subsection (5)(b)(iii), for behavioral health, through the
2381 counties in accordance with Sections [17-43-201](#) and [17-43-301](#);

2382 (iii) that, subject to Section [~~26-18-428~~] [26B-3-223](#), integrates behavioral health
2383 services and physical health services with Medicaid accountable care organizations in select
2384 geographic areas of the state that choose an integrated model; and

2385 (iv) that permits temporary residential treatment for substance [~~abuse~~] use in a short
2386 term, non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that
2387 provides rehabilitation services that are medically necessary and in accordance with an
2388 individualized treatment plan.

2389 (6) (a) An individual is eligible for the health coverage improvement program under
2390 Subsection (5) if:

2391 (i) at the time of enrollment, the individual's annual income is below the income
2392 eligibility ceiling established by the state under Subsection (1)(f); and

2393 (ii) the individual meets the eligibility criteria established by the department under
2394 Subsection (6)(b).

2395 (b) Based on available funding and approval from CMS, the department shall select the
2396 criteria for an individual to qualify for the Medicaid program under Subsection (6)(a)(ii), based
2397 on the following priority:

2398 (i) a chronically homeless individual;

2399 (ii) if funding is available, an individual:

2400 (A) involved in the justice system through probation, parole, or court ordered
2401 treatment; and

2402 (B) in need of substance [~~abuse~~] use treatment or mental health treatment, as
2403 determined by the department; or

2404 (iii) if funding is available, an individual in need of substance [~~abuse~~] use treatment or

2405 mental health treatment, as determined by the department.

2406 (c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)
2407 may remain on the Medicaid program for a 12-month certification period as defined by the
2408 department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall
2409 not apply to an individual during the 12-month certification period.

2410 (7) The state may request a modification of the income eligibility ceiling and other
2411 eligibility criteria under Subsection (6) each fiscal year based on projected enrollment, costs to
2412 the state, and the state budget.

2413 (8) The current Medicaid program and the health coverage improvement program,
2414 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
2415 enrollment for an individual who is released from custody and was eligible for or enrolled in
2416 Medicaid before incarceration.

2417 (9) Notwithstanding Sections [17-43-201](#) and [17-43-301](#), a county does not have to
2418 provide matching funds to the state for the cost of providing Medicaid services to newly
2419 enrolled individuals who qualify for Medicaid coverage under the health coverage
2420 improvement program under Subsection (6).

2421 (10) If the enhancement waiver program is implemented, the department:

2422 (a) may not accept any new enrollees into the health coverage improvement program
2423 after the day on which the enhancement waiver program is implemented;

2424 (b) shall transition all individuals who are enrolled in the health coverage improvement
2425 program into the enhancement waiver program;

2426 (c) shall suspend the health coverage improvement program within one year after the
2427 day on which the enhancement waiver program is implemented;

2428 (d) shall, within one year after the day on which the enhancement waiver program is
2429 implemented, use all appropriations for the health coverage improvement program to
2430 implement the enhancement waiver program; and

2431 (e) shall work with CMS to maintain any waiver for the health coverage improvement

2432 program while the health coverage improvement program is suspended under Subsection [~~(11)~~]
2433 (10)(c).

2434 (11) If, after the enhancement waiver program takes effect, the enhancement waiver
2435 program is repealed or suspended by either the state or federal government, the department
2436 shall reinstate the health coverage improvement program and continue to accept new enrollees
2437 into the health coverage improvement program in accordance with the provisions of this
2438 section.

2439 Section 49. Section **26B-3-208**, which is renumbered from Section 26-18-413 is
2440 renumbered and amended to read:

2441 ~~[26-18-413]~~. **26B-3-208**. **Medicaid waiver for delivery of adult dental**
2442 **services.**

2443 (1) (a) Before June 30, 2016, the department shall ask CMS to grant waivers from
2444 federal statutory and regulatory law necessary for the Medicaid program to provide dental
2445 services in the manner described in Subsection (2)(a).

2446 (b) Before June 30, 2018, the department shall submit to CMS a request for waivers, or
2447 an amendment of existing waivers, from federal law necessary for the state to provide dental
2448 services, in accordance with Subsections (2)(b)(i) and (d) through (g), to an individual
2449 described in Subsection (2)(b)(i).

2450 (c) Before June 30, 2019, the department shall submit to the Centers for Medicare and
2451 Medicaid Services a request for waivers, or an amendment to existing waivers, from federal
2452 law necessary for the state to:

2453 (i) provide dental services, in accordance with Subsections (2)(b)(ii) and (d) through
2454 (g) to an individual described in Subsection (2)(b)(ii); and

2455 (ii) provide the services described in Subsection (2)(h).

2456 (2) (a) To the extent funded, the department shall provide services to only blind or
2457 disabled individuals, as defined in 42 U.S.C. Sec. 1382c(a)(1), who are 18 years old or older
2458 and eligible for the program.

- 2459 (b) Notwithstanding Subsection (2)(a):
- 2460 (i) if a waiver is approved under Subsection (1)(b), the department shall provide dental
- 2461 services to an individual who:
- 2462 (A) qualifies for the health coverage improvement program described in Section
- 2463 ~~[26-18-411]~~ [26B-3-207](#); and
- 2464 (B) is receiving treatment in a substance abuse treatment program, as defined in
- 2465 Section ~~[62A-2-101]~~ [26B-2-101](#), licensed under ~~[Title 62A, Chapter 2, Licensure of Programs~~
- 2466 ~~and Facilities]~~ [Chapter 2, Part 1, Human Services Programs and Facilities](#); and
- 2467 (ii) if a waiver is approved under Subsection (1)(c)(i), the department shall provide
- 2468 dental services to an individual who is an aged individual as defined in 42 U.S.C. Sec.
- 2469 1382c(a)(1).
- 2470 (c) To the extent possible, services to individuals described in Subsection (2)(a) shall
- 2471 be provided through the University of Utah School of Dentistry and the University of Utah
- 2472 School of Dentistry's associated statewide network.
- 2473 (d) The department shall provide the services to individuals described in Subsection
- 2474 (2)(b):
- 2475 (i) by contracting with an entity that:
- 2476 (A) has demonstrated experience working with individuals who are being treated for
- 2477 both a substance use disorder and a major oral health disease;
- 2478 (B) operates a program, targeted at the individuals described in Subsection (2)(b), that
- 2479 has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental
- 2480 treatment to those individuals described in Subsection (2)(b);
- 2481 (C) is willing to pay for an amount equal to the program's non-federal share of the cost
- 2482 of providing dental services to the population described in Subsection (2)(b); and
- 2483 (D) is willing to pay all state costs associated with applying for the waiver described in
- 2484 Subsection (1)(b) and administering the program described in Subsection (2)(b); and
- 2485 (ii) through a fee-for-service payment model.

2486 (e) The entity that receives the contract under Subsection (2)(d)(i) shall cover all state
2487 costs of the program described in Subsection (2)(b).

2488 (f) Each fiscal year, the University of Utah School of Dentistry shall, in compliance
2489 with state and federal regulations regarding intergovernmental transfers, transfer funds to the
2490 program in an amount equal to the program's non-federal share of the cost of providing services
2491 under this section through the school during the fiscal year.

2492 (g) If a waiver is approved under Subsection (1)(c)(ii), the department shall provide
2493 coverage for porcelain and porcelain-to-metal crowns if the services are provided:

2494 (i) to an individual who qualifies for dental services under Subsection (2)(b); and

2495 (ii) by an entity that covers all state costs of:

2496 (A) providing the coverage described in this Subsection [~~(2)(h)~~] (2)(g); and

2497 (B) applying for the waiver described in Subsection (1)(c).

2498 (h) Where possible, the department shall ensure that services described in Subsection
2499 (2)(a) that are not provided by the University of Utah School of Dentistry or the University of
2500 Utah School of Dentistry's associated network are provided:

2501 (i) through fee for service reimbursement until July 1, 2018; and

2502 (ii) after July 1, 2018, through the method of reimbursement used by the division for
2503 Medicaid dental benefits.

2504 (i) Subject to appropriations by the Legislature, and as determined by the department,
2505 the scope, amount, duration, and frequency of services may be limited.

2506 (3) (a) If the waivers requested under Subsection (1)(a) are granted, the Medicaid
2507 program shall begin providing dental services in the manner described in Subsection (2) no
2508 later than July 1, 2017.

2509 (b) If the waivers requested under Subsection (1)(b) are granted, the Medicaid program
2510 shall begin providing dental services to the population described in Subsection (2)(b) within 90
2511 days from the day on which the waivers are granted.

2512 (c) If the waivers requested under Subsection (1)(c)(i) are granted, the Medicaid

2513 program shall begin providing dental services to the population described in Subsection
2514 (2)(b)(ii) within 90 days after the day on which the waivers are granted.

2515 (4) If the federal share of the cost of providing dental services under this section will be
2516 less than 65% during any portion of the next fiscal year, the Medicaid program shall cease
2517 providing dental services under this section no later than the end of the current fiscal year.

2518 Section 50. Section **26B-3-209**, which is renumbered from Section 26-18-414 is
2519 renumbered and amended to read:

2520 ~~[26-18-414]~~. **26B-3-209. Medicaid long-term support services housing**
2521 **coordinator.**

2522 (1) There is created within the Medicaid program a full-time-equivalent position of
2523 Medicaid long-term support services housing coordinator.

2524 (2) The coordinator shall help Medicaid recipients receive long-term support services
2525 in a home or other community-based setting rather than in a nursing home or other institutional
2526 setting by:

2527 (a) working with municipalities, counties, the Housing and Community Development
2528 Division within the Department of Workforce Services, and others to identify
2529 community-based settings available to recipients;

2530 (b) working with the same entities to promote the development, construction, and
2531 availability of additional community-based settings;

2532 (c) training Medicaid case managers and support coordinators on how to help Medicaid
2533 recipients move from an institutional setting to a community-based setting; and

2534 (d) performing other related duties.

2535 Section 51. Section **26B-3-210**, which is renumbered from Section 26-18-415 is
2536 renumbered and amended to read:

2537 ~~[26-18-415]~~. **26B-3-210. Medicaid waiver expansion.**

2538 (1) As used in this section:

2539 (a) "Federal poverty level" means the same as that term is defined in Section

2540 [~~26-18-411~~] [26B-3-207](#).

2541 (b) "Medicaid waiver expansion" means an expansion of the Medicaid program in
2542 accordance with this section.

2543 (2) (a) Before January 1, 2019, the department shall apply to CMS for approval of a
2544 waiver or state plan amendment to implement the Medicaid waiver expansion.

2545 (b) The Medicaid waiver expansion shall:

2546 (i) expand Medicaid coverage to eligible individuals whose income is below 95% of
2547 the federal poverty level;

2548 (ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for
2549 enrolling an individual in the Medicaid program;

2550 (iii) provide Medicaid benefits through the state's Medicaid accountable care
2551 organizations in areas where a Medicaid accountable care organization is implemented;

2552 (iv) integrate the delivery of behavioral health services and physical health services
2553 with Medicaid accountable care organizations in select geographic areas of the state that
2554 choose an integrated model;

2555 (v) include a path to self-sufficiency, including work activities as defined in 42 U.S.C.
2556 Sec. 607(d), for qualified adults;

2557 (vi) require an individual who is offered a private health benefit plan by an employer to
2558 enroll in the employer's health plan;

2559 (vii) sunset in accordance with Subsection (5)(a); and

2560 (viii) permit the state to close enrollment in the Medicaid waiver expansion if the
2561 department has insufficient funding to provide services to additional eligible individuals.

2562 (3) If the Medicaid waiver described in Subsection (2)(a) is approved, the department
2563 may only pay the state portion of costs for the Medicaid waiver expansion with appropriations
2564 from:

2565 (a) the Medicaid Expansion Fund, created in Section [~~26-36b-208~~] [26B-1-315](#);

2566 (b) county contributions to the non-federal share of Medicaid expenditures; and

2567 (c) any other contributions, funds, or transfers from a non-state agency for Medicaid
2568 expenditures.

2569 (4) (a) In consultation with the department, Medicaid accountable care organizations
2570 and counties that elect to integrate care under Subsection (2)(b)(iv) shall collaborate on
2571 enrollment, engagement of patients, and coordination of services.

2572 (b) As part of the provision described in Subsection (2)(b)(iv), the department shall
2573 apply for a waiver to permit the creation of an integrated delivery system:

2574 (i) for any geographic area that expresses interest in integrating the delivery of services
2575 under Subsection (2)(b)(iv); and

2576 (ii) in which the department:

2577 (A) may permit a local mental health authority to integrate the delivery of behavioral
2578 health services and physical health services;

2579 (B) may permit a county, local mental health authority, or Medicaid accountable care
2580 organization to integrate the delivery of behavioral health services and physical health services
2581 to select groups within the population that are newly eligible under the Medicaid waiver
2582 expansion; and

2583 (C) may make rules in accordance with Title 63G, Chapter 3, Utah Administrative
2584 Rulemaking Act, to integrate payments for behavioral health services and physical health
2585 services to plans or providers.

2586 (5) (a) If federal financial participation for the Medicaid waiver expansion is reduced
2587 below 90%, the authority of the department to implement the Medicaid waiver expansion shall
2588 sunset no later than the next July 1 after the date on which the federal financial participation is
2589 reduced.

2590 (b) The department shall close the program to new enrollment if the cost of the
2591 Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are
2592 authorized by the Legislature through an appropriations act adopted in accordance with Title
2593 63J, Chapter 1, Budgetary Procedures Act.

2594 (6) If the Medicaid waiver expansion is approved by CMS, the department shall report
2595 to the Social Services Appropriations Subcommittee on or before November 1 of each year that
2596 the Medicaid waiver expansion is operational:

- 2597 (a) the number of individuals who enrolled in the Medicaid waiver program;
- 2598 (b) costs to the state for the Medicaid waiver program;
- 2599 (c) estimated costs for the current and following state fiscal year; and
- 2600 (d) recommendations to control costs of the Medicaid waiver expansion.

2601 Section 52. Section **26B-3-211**, which is renumbered from Section 26-18-416 is
2602 renumbered and amended to read:

2603 ~~[26-18-416]~~. **26B-3-211. Primary Care Network enhancement waiver**
2604 **program.**

2605 (1) As used in this section:

2606 (a) "Enhancement waiver program" means the Primary Care Network enhancement
2607 waiver program described in this section.

2608 (b) "Federal poverty level" means the poverty guidelines established by the secretary of
2609 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9902(2).

2610 (c) "Health coverage improvement program" means the same as that term is defined in
2611 Section ~~[26-18-411]~~ [26B-3-207](#).

2612 (d) "Income eligibility ceiling" means the percentage of federal poverty level:

2613 (i) established by the Legislature in an appropriations act adopted pursuant to Title 63J,
2614 Chapter 1, Budgetary Procedures Act; and

2615 (ii) under which an individual may qualify for coverage in the enhancement waiver
2616 program in accordance with this section.

2617 (e) "Optional population" means the optional expansion population under PPACA if
2618 the expansion provides coverage for individuals at or above 95% of the federal poverty level.

2619 (f) "Primary Care Network" means the state Primary Care Network program created by
2620 the Medicaid primary care network demonstration waiver obtained under Section ~~[26-18-3]~~

2621 [26B-3-108](#).

2622 (2) The department shall continue to implement the Primary Care Network program for
2623 qualified individuals under the Primary Care Network program.

2624 (3) (a) The division shall apply for a Medicaid waiver or a state plan amendment with
2625 CMS to implement, within the state Medicaid program, the enhancement waiver program
2626 described in this section within six months after the day on which:

2627 (i) the division receives a notice from CMS that the waiver for the Medicaid waiver
2628 expansion submitted under Section [~~26-18-415~~] [26B-3-210](#), Medicaid waiver expansion, will
2629 not be approved; or

2630 (ii) the division withdraws the waiver for the Medicaid waiver expansion submitted
2631 under Section [~~26-18-415~~] [26B-3-210](#), Medicaid waiver expansion.

2632 (b) The division may not apply for a waiver under Subsection (3)(a) while a waiver
2633 request under Section [~~26-18-415~~] [26B-3-210](#), Medicaid waiver expansion, is pending with
2634 CMS.

2635 (4) An individual who is eligible for the enhancement waiver program may receive the
2636 following benefits under the enhancement waiver program:

2637 (a) the benefits offered under the Primary Care Network program;

2638 (b) diagnostic testing and procedures;

2639 (c) medical specialty care;

2640 (d) inpatient hospital services;

2641 (e) outpatient hospital services;

2642 (f) outpatient behavioral health care, including outpatient substance [~~abuse~~] use care;

2643 and

2644 (g) for an individual who qualifies for the health coverage improvement program, as
2645 approved by CMS, temporary residential treatment for substance [~~abuse~~] use in a short term,
2646 non-institutional, 24-hour facility, without a bed capacity limit, that provides rehabilitation
2647 services that are medically necessary and in accordance with an individualized treatment plan.

2648 (5) An individual is eligible for the enhancement waiver program if, at the time of
2649 enrollment:

2650 (a) the individual is qualified to enroll in the Primary Care Network or the health
2651 coverage improvement program;

2652 (b) the individual's annual income is below the income eligibility ceiling established by
2653 the Legislature under Subsection (1)(d); and

2654 (c) the individual meets the eligibility criteria established by the department under
2655 Subsection (6).

2656 (6) (a) Based on available funding and approval from CMS, the department shall
2657 determine the criteria for an individual to qualify for the enhancement waiver program, based
2658 on the following priority:

2659 (i) adults in the expansion population, as defined in Section [~~26-18-411~~] [26B-3-207](#),
2660 who qualify for the health coverage improvement program;

2661 (ii) adults with dependent children who qualify for the health coverage improvement
2662 program under Subsection [~~26-18-411~~] [26B-3-207](#)(3);

2663 (iii) adults with dependent children who do not qualify for the health coverage
2664 improvement program; and

2665 (iv) if funding is available, adults without dependent children.

2666 (b) The number of individuals enrolled in the enhancement waiver program may not
2667 exceed 105% of the number of individuals who were enrolled in the Primary Care Network on
2668 December 31, 2017.

2669 (c) The department may only use appropriations from the Medicaid Expansion Fund
2670 created in Section [~~26-36b-208~~] [26B-1-315](#) to fund the state portion of the enhancement waiver
2671 program.

2672 (7) The department may request a modification of the income eligibility ceiling and the
2673 eligibility criteria under Subsection (6) from CMS each fiscal year based on enrollment in the
2674 enhancement waiver program, projected enrollment in the enhancement waiver program, costs

2675 to the state, and the state budget.

2676 (8) The department may implement the enhancement waiver program by contracting
2677 with Medicaid accountable care organizations to administer the enhancement waiver program.

2678 (9) In accordance with Subsections [~~26-18-411(11) and (12)~~] 26B-3-207(10) and (11),
2679 the department may use funds that have been appropriated for the health coverage
2680 improvement program to implement the enhancement waiver program.

2681 (10) If the department expands the state Medicaid program to the optional population,
2682 the department:

2683 (a) except as provided in Subsection (11), may not accept any new enrollees into the
2684 enhancement waiver program after the day on which the expansion to the optional population
2685 is effective;

2686 (b) shall suspend the enhancement waiver program within one year after the day on
2687 which the expansion to the optional population is effective; and

2688 (c) shall work with CMS to maintain the waiver for the enhancement waiver program
2689 submitted under Subsection (3) while the enhancement waiver program is suspended under
2690 Subsection (10)(b).

2691 (11) If, after the expansion to the optional population described in Subsection (10)
2692 takes effect, the expansion to the optional population is repealed by either the state or the
2693 federal government, the department shall reinstate the enhancement waiver program and
2694 continue to accept new enrollees into the enhancement waiver program in accordance with the
2695 provisions of this section.

2696 Section 53. Section **26B-3-212**, which is renumbered from Section 26-18-417 is
2697 renumbered and amended to read:

2698 [~~26-18-417~~]. **26B-3-212. Limited family planning services for low-income**
2699 **individuals.**

2700 (1) As used in this section:

2701 (a) (i) "Family planning services" means family planning services that are provided

2702 under the state Medicaid program, including:

2703 (A) sexual health education and family planning counseling; and

2704 (B) other medical diagnosis, treatment, or preventative care routinely provided as part
2705 of a family planning service visit.

2706 (ii) "Family planning services" do not include an abortion, as that term is defined in
2707 Section [76-7-301](#).

2708 (b) "Low-income individual" means an individual who:

2709 (i) has an income level that is equal to or below 95% of the federal poverty level; and

2710 (ii) does not qualify for full coverage under the Medicaid program.

2711 (2) Before July 1, 2018, the division shall apply for a Medicaid waiver or a state plan
2712 amendment with CMS to:

2713 (a) offer a program that provides family planning services to low-income individuals;
2714 and

2715 (b) receive a federal match rate of 90% of state expenditures for family planning
2716 services provided under the waiver or state plan amendment.

2717 Section 54. Section **26B-3-213**, which is renumbered from Section 26-18-418 is
2718 renumbered and amended to read:

2719 ~~[26-18-418]~~. **26B-3-213. Medicaid waiver for mental health crisis lines**
2720 **and mobile crisis outreach teams.**

2721 (1) As used in this section:

2722 (a) "Local mental health crisis line" means the same as that term is defined in Section
2723 ~~[62A-15-1301]~~ [26B-5-610](#).

2724 (b) "Mental health crisis" means:

2725 (i) a mental health condition that manifests itself in an individual by symptoms of
2726 sufficient severity that a prudent layperson who possesses an average knowledge of mental
2727 health issues could reasonably expect the absence of immediate attention or intervention to
2728 result in:

2729 (A) serious danger to the individual's health or well-being; or
2730 (B) a danger to the health or well-being of others; or
2731 (ii) a mental health condition that, in the opinion of a mental health therapist or the
2732 therapist's designee, requires direct professional observation or the intervention of a mental
2733 health therapist.

2734 (c) (i) "Mental health crisis services" means direct mental health services and on-site
2735 intervention that a mobile crisis outreach team provides to an individual suffering from a
2736 mental health crisis, including the provision of safety and care plans, prolonged mental health
2737 services for up to 90 days, and referrals to other community resources.

2738 (ii) "Mental health crisis services" includes:
2739 (A) local mental health crisis lines; and
2740 (B) the statewide mental health crisis line.

2741 (d) "Mental health therapist" means the same as that term is defined in Section
2742 [58-60-102](#).

2743 (e) "Mobile crisis outreach team" or "MCOT" means a mobile team of medical and
2744 mental health professionals that, in coordination with local law enforcement and emergency
2745 medical service personnel, provides mental health crisis services.

2746 (f) "Statewide mental health crisis line" means the same as that term is defined in
2747 Section [~~62A-15-1301~~] [26B-5-610](#).

2748 (2) In consultation with [~~the Department of Human Services and~~] the Behavioral
2749 Health Crisis Response Commission created in Section [63C-18-202](#), the department shall
2750 develop a proposal to amend the state Medicaid plan to include mental health crisis services,
2751 including the statewide mental health crisis line, local mental health crisis lines, and mobile
2752 crisis outreach teams.

2753 (3) By January 1, 2019, the department shall apply for a Medicaid waiver with CMS, if
2754 necessary to implement, within the state Medicaid program, the mental health crisis services
2755 described in Subsection (2).

2756 Section 55. Section **26B-3-214**, which is renumbered from Section 26-18-419 is
2757 renumbered and amended to read:

2758 ~~[26-18-419]~~. **26B-3-214**. **Medicaid waiver for coverage of mental health**
2759 **services in schools.**

2760 (1) As used in this section, "local education agency" means:

- 2761 (a) a school district;
- 2762 (b) a charter school; or
- 2763 (c) the Utah Schools for the Deaf and the Blind.

2764 (2) In consultation with [~~the Department of Human Services and~~] the State Board of
2765 Education, the department shall develop a proposal to allow the state Medicaid program to
2766 reimburse a local education agency, a local mental health authority, or a private provider for
2767 covered mental health services provided:

- 2768 (a) in accordance with Section **53E-9-203**; and
- 2769 (b) (i) at a local education agency building or facility; or
- 2770 (ii) by an employee or contractor of a local education agency.

2771 (3) Before January 1, 2020, the department shall apply to CMS for a state plan
2772 amendment to implement the coverage described in Subsection (2).

2773 Section 56. Section **26B-3-215**, which is renumbered from Section 26-18-420 is
2774 renumbered and amended to read:

2775 ~~[26-18-420]~~. **26B-3-215**. **Coverage for in vitro fertilization and genetic**
2776 **testing.**

2777 (1) As used in this section:

- 2778 (a) "Qualified condition" means:
 - 2779 (i) cystic fibrosis;
 - 2780 (ii) spinal muscular atrophy;
 - 2781 (iii) Morquio Syndrome;
 - 2782 (iv) myotonic dystrophy; or

2783 (v) sickle cell anemia.

2784 (b) "Qualified enrollee" means an individual who:

2785 (i) is enrolled in the Medicaid program;

2786 (ii) has been diagnosed by a physician as having a genetic trait associated with a

2787 qualified condition; and

2788 (iii) intends to get pregnant with a partner who is diagnosed by a physician as having a

2789 genetic trait associated with the same qualified condition as the individual.

2790 (2) Before January 1, 2021, the department shall apply for a Medicaid waiver or a state

2791 plan amendment with the Centers for Medicare and Medicaid Services within the United States

2792 Department of Health and Human Services to implement the coverage described in Subsection

2793 (3).

2794 (3) If the waiver described in Subsection (2) is approved, the Medicaid program shall

2795 provide coverage to a qualified enrollee for:

2796 (a) in vitro fertilization services; and

2797 (b) genetic testing of a qualified enrollee who receives in vitro fertilization services

2798 under Subsection (3)(a).

2799 (4) The Medicaid program may not provide the coverage described in Subsection (3)

2800 before the later of:

2801 (a) the day on which the waiver described in Subsection (2) is approved; and

2802 (b) January 1, 2021.

2803 (5) Before November 1, 2022, and before November 1 of every third year thereafter,

2804 the department shall:

2805 (a) calculate the change in state spending attributable to the coverage under this

2806 section; and

2807 (b) report the amount described in Subsection [~~(4)(a)~~] (5)(a) to the Health and Human

2808 Services Interim Committee and the Social Services Appropriations Subcommittee.

2809 Section 57. Section **26B-3-216**, which is renumbered from Section 26-18-420.1 is

2810 renumbered and amended to read:

2811 ~~[26-18-420.1]~~. **26B-3-216. Medicaid waiver for fertility preservation**
2812 **services.**

2813 (1) As used in this section:

2814 (a) "Iatrogenic infertility" means an impairment of fertility or reproductive functioning
2815 caused by surgery, chemotherapy, radiation, or other medical treatment.

2816 (b) "Physician" means an individual licensed to practice under Title 58, Chapter 67,
2817 Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

2818 (c) "Qualified enrollee" means an individual who:

2819 (i) is enrolled in the Medicaid program;

2820 (ii) has been diagnosed with a form of cancer by a physician; and

2821 (iii) needs treatment for that cancer that may cause a substantial risk of sterility or
2822 iatrogenic infertility, including surgery, radiation, or chemotherapy.

2823 (d) "Standard fertility preservation service" means a fertility preservation procedure
2824 and service that:

2825 (i) is not considered experimental or investigational by the American Society for
2826 Reproductive Medicine or the American Society of Clinical Oncology; and

2827 (ii) is consistent with established medical practices or professional guidelines
2828 published by the American Society for Reproductive Medicine or the American Society of
2829 Clinical Oncology, including:

2830 (A) sperm banking;

2831 (B) oocyte banking;

2832 (C) embryo banking;

2833 (D) banking of reproductive tissues; and

2834 (E) storage of reproductive cells and tissues.

2835 (2) Before January 1, 2022, the department shall apply for a Medicaid waiver or a state
2836 plan amendment with CMS to implement the coverage described in Subsection (3).

2837 (3) If the waiver or state plan amendment described in Subsection (2) is approved, the
2838 Medicaid program shall provide coverage to a qualified enrollee for standard fertility
2839 preservation services.

2840 (4) The Medicaid program may not provide the coverage described in Subsection (3)
2841 before the later of:

2842 (a) the day on which the waiver described in Subsection (2) is approved; and

2843 (b) January 1, 2023.

2844 (5) Before November 1, 2023, and before November 1 of each third year after 2023,
2845 the department shall:

2846 (a) calculate the change in state spending attributable to the coverage described in this
2847 section; and

2848 (b) report the amount described in Subsection (5)(a) to the Health and Human Services
2849 Interim Committee and the Social Services Appropriations Subcommittee.

2850 Section 58. Section **26B-3-217**, which is renumbered from Section 26-18-421 is
2851 renumbered and amended to read:

2852 ~~[26-18-421]~~. **26B-3-217**. **Medicaid waiver for coverage of qualified**
2853 **inmates leaving prison or jail.**

2854 (1) As used in this section:

2855 (a) "Correctional facility" means:

2856 (i) a county jail;

2857 (ii) the Department of Corrections, created in Section [64-13-2](#); or

2858 (iii) a prison, penitentiary, or other institution operated by or under contract with the
2859 Department of Corrections for the confinement of an offender, as defined in Section [64-13-1](#).

2860 (b) "Qualified inmate" means an individual who:

2861 (i) is incarcerated in a correctional facility; and

2862 (ii) has:

2863 (A) a chronic physical or behavioral health condition;

2864 (B) a mental illness, as defined in Section [~~62A-15-602~~] 26B-5-301; or

2865 (C) an opioid use disorder.

2866 (2) Before July 1, 2020, the division shall apply for a Medicaid waiver or a state plan
2867 amendment with CMS to offer a program to provide Medicaid coverage to a qualified inmate
2868 for up to 30 days immediately before the day on which the qualified inmate is released from a
2869 correctional facility.

2870 (3) If the waiver or state plan amendment described in Subsection (2) is approved, the
2871 department shall report to the Health and Human Services Interim Committee each year before
2872 November 30 while the waiver or state plan amendment is in effect regarding:

2873 (a) the number of qualified inmates served under the program;

2874 (b) the cost of the program; and

2875 (c) the effectiveness of the program, including:

2876 (i) any reduction in the number of emergency room visits or hospitalizations by
2877 inmates after release from a correctional facility;

2878 (ii) any reduction in the number of inmates undergoing inpatient treatment after release
2879 from a correctional facility;

2880 (iii) any reduction in overdose rates and deaths of inmates after release from a
2881 correctional facility; and

2882 (iv) any other costs or benefits as a result of the program.

2883 (4) If the waiver or state plan amendment described in Subsection (2) is approved, a
2884 county that is responsible for the cost of a qualified inmate's medical care shall provide the
2885 required matching funds to the state for:

2886 (a) any costs to enroll the qualified inmate for the Medicaid coverage described in
2887 Subsection (2);

2888 (b) any administrative fees for the Medicaid coverage described in Subsection (2); and

2889 (c) the Medicaid coverage that is provided to the qualified inmate under Subsection

2890 (2).

2891 Section 59. Section **26B-3-218**, which is renumbered from Section 26-18-422 is
2892 renumbered and amended to read:

2893 ~~[26-18-422]~~. **26B-3-218**. **Medicaid waiver for inpatient care in an**
2894 **institution for mental diseases.**

2895 (1) As used in this section, "institution for mental diseases" means the same as that
2896 term is defined in 42 C.F.R. Sec. 435.1010.

2897 (2) Before August 1, 2020, the division shall apply for a Medicaid waiver or a state
2898 plan amendment with CMS to offer a program that provides reimbursement for mental health
2899 services that are provided:

2900 (a) in an institution for mental diseases that includes more than 16 beds; and

2901 (b) to an individual who receives mental health services in an institution for mental
2902 diseases for a period of more than 15 days in a calendar month.

2903 (3) If the waiver or state plan amendment described in Subsection (2) is approved, the
2904 department shall:

2905 (a) ~~[coordinate with the Department of Human Services to]~~ develop and offer the
2906 program described in Subsection (2); and

2907 (b) submit to the Health and Human Services Interim Committee and the Social
2908 Services Appropriations Subcommittee any report that the department submits to CMS that
2909 relates to the budget neutrality, independent waiver evaluation, or performance metrics of the
2910 program described in Subsection (2), within 15 days after the day on which the report is
2911 submitted to CMS.

2912 (4) Notwithstanding Sections [17-43-201](#) and [17-43-301](#), if the waiver or state plan
2913 amendment described in Subsection (2) is approved, a county does not have to provide
2914 matching funds to the state for the mental health services described in Subsection (2) that are
2915 provided to an individual who qualifies for Medicaid coverage under Section ~~[26-18-3.9 or~~
2916 ~~Section 26-18-411]~~ [26B-3-113](#) or [26B-3-207](#).

2917 Section 60. Section **26B-3-219**, which is renumbered from Section 26-18-423 is

2918 renumbered and amended to read:

2919 ~~[26-18-423]~~. **26B-3-219. Reimbursement for crisis management services**
2920 **provided in a behavioral health receiving center -- Integration of payment for physical**
2921 **health services.**

2922 (1) As used in this section:

2923 (a) "Accountable care organization" means the same as that term is defined in Section
2924 ~~[26-18-408]~~ 26B-3-204.

2925 (b) "Behavioral health receiving center" means the same as that term is defined in
2926 Section ~~[62A-15-118]~~ 26B-4-114.

2927 (c) "Crisis management services" means behavioral health services provided to an
2928 individual who is experiencing a mental health crisis.

2929 (d) "Managed care organization" means the same as that term is defined in 42 C.F.R.
2930 Sec. 438.2.

2931 (2) Before July 1, 2020, the division shall apply for a Medicaid waiver or state plan
2932 amendment with CMS to offer a program that provides reimbursement through a bundled daily
2933 rate for crisis management services that are delivered to an individual during the individual's
2934 stay at a behavioral health receiving center.

2935 (3) If the waiver or state plan amendment described in Subsection (2) is approved, the
2936 department shall:

2937 (a) implement the program described in Subsection (2); and

2938 (b) require a managed care organization that contracts with the state's Medicaid
2939 program for behavioral health services or integrated health services to provide coverage for
2940 crisis management services that are delivered to an individual during the individual's stay at a
2941 behavioral health receiving center.

2942 (4) (a) The department may elect to integrate payment for physical health services
2943 provided in a behavioral health receiving center.

2944 (b) In determining whether to integrate payment under Subsection (4)(a), the

2945 department shall consult with accountable care organizations and counties in the state.

2946 Section 61. Section **26B-3-220**, which is renumbered from Section 26-18-424 is
2947 renumbered and amended to read:

2948 ~~[26-18-424]~~. **26B-3-220. Crisis services -- Reimbursement.**

2949 The ~~[Department]~~ department shall submit a waiver or state plan amendment to allow
2950 for reimbursement for 988 services provided to an individual who is eligible and enrolled in
2951 Medicaid at the time this service is provided.

2952 Section 62. Section **26B-3-221**, which is renumbered from Section 26-18-425 is
2953 renumbered and amended to read:

2954 ~~[26-18-425]~~. **26B-3-221. Medicaid waiver for respite care facility that**
2955 **provides services to homeless individuals.**

2956 (1) As used in this section:

2957 (a) "Adult in the expansion population" means an adult:

2958 (i) described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and

2959 (ii) not otherwise eligible for Medicaid as a mandatory categorically needy individual.

2960 (b) "Homeless" means the same as that term is defined in Section ~~[26-18-411]~~

2961 [26B-3-207](#).

2962 (c) "Medical respite care" means short-term housing with supportive medical services.

2963 (d) "Medical respite facility" means a residential facility that provides medical respite
2964 care to homeless individuals.

2965 (2) Before January 1, 2022, the department shall apply for a Medicaid waiver or state
2966 plan amendment with CMS to choose a single medical respite facility to reimburse for services
2967 provided to an individual who is:

2968 (a) homeless; and

2969 (b) an adult in the expansion population.

2970 (3) The department shall choose a medical respite facility best able to serve homeless
2971 individuals who are adults in the expansion population.

2972 (4) If the waiver or state plan amendment described in Subsection (2) is approved,
2973 while the waiver or state plan amendment is in effect, the department shall submit a report to
2974 the Health and Human Services Interim Committee each year before November 30 detailing:

- 2975 (a) the number of homeless individuals served at the facility;
- 2976 (b) the cost of the program; and
- 2977 (c) the reduction of health care costs due to the program's implementation.

2978 (5) Through administrative rule made in accordance with Title 63G, Chapter 3, Utah
2979 Administrative Rulemaking Act, the department shall further define and limit the services,
2980 described in this section, provided to a homeless individual.

2981 Section 63. Section **26B-3-222**, which is renumbered from Section 26-18-426 is
2982 renumbered and amended to read:

2983 ~~[26-18-426]~~. **26B-3-222**. **Medicaid waiver expansion for extraordinary**
2984 **care reimbursement.**

2985 (1) As used in this section:

2986 (a) "Existing home and community-based services waiver" means an existing home
2987 and community-based services waiver in the state that serves an individual:

- 2988 (i) with an acquired brain injury;
- 2989 (ii) with an intellectual or physical disability; or
- 2990 (iii) who is 65 years old or older.

2991 (b) "Personal care services" means a service that:

- 2992 (i) is furnished to an individual who is not an inpatient nor a resident of a hospital,
2993 nursing facility, intermediate care facility, or institution for mental diseases;
- 2994 (ii) is authorized for an individual described in Subsection (1)(b)(i) in accordance with
2995 a plan of treatment;
- 2996 (iii) is provided by an individual who is qualified to provide the services; and
- 2997 (iv) is furnished in a home or another community-based setting.

2998 (c) "Waiver enrollee" means an individual who is enrolled in an existing home and

2999 community-based services waiver.

3000 (2) Before July 1, 2021, the department shall apply with CMS for an amendment to an
3001 existing home and community-based services waiver to implement a program to offer
3002 reimbursement to an individual who provides personal care services that constitute
3003 extraordinary care to a waiver enrollee who is the individual's spouse.

3004 (3) If CMS approves the amendment described in Subsection (2), the department shall
3005 implement the program described in Subsection (2).

3006 (4) The department shall by rule, made in accordance with Title 63G, Chapter 3, Utah
3007 Administrative Rulemaking Act, define "extraordinary care" for purposes of Subsection (2).

3008 Section 64. Section **26B-3-223**, which is renumbered from Section 26-18-428 is
3009 renumbered and amended to read:

3010 ~~[26-18-428]~~. **26B-3-223**. **Delivery system adjustments for the targeted**
3011 **adult Medicaid program.**

3012 (1) As used in this section, "targeted adult Medicaid program" means the same as that
3013 term is defined in Section ~~[26-18-411]~~ 26B-3-207.

3014 (2) The department may implement the delivery system adjustments authorized under
3015 Subsection (3) only on the later of:

3016 (a) July 1, 2023; and

3017 (b) the department determining that the Medicaid program, including providers and
3018 managed care organizations, are satisfying the metrics established in collaboration with the
3019 working group convened under Subsection ~~[26-18-427]~~ 26B-3-138(2).

3020 (3) The department may, for individuals who are enrolled in the targeted adult
3021 Medicaid program:

3022 (a) integrate the delivery of behavioral and physical health in certain counties; and

3023 (b) deliver behavioral health services through an accountable care organization where
3024 implemented.

3025 (4) Before implementing the delivery system adjustments described in Subsection (3)

3026 in a county, the department shall, at a minimum, seek input from:

3027 (a) individuals who qualify for the targeted adult Medicaid program who reside in the
3028 county;

3029 (b) the county's executive officer, legislative body, and other county officials who are
3030 involved in the delivery of behavioral health services;

3031 (c) the local mental health authority and local substance [~~use~~] abuse authority that
3032 serves the county;

3033 (d) Medicaid managed care organizations operating in the state, including Medicaid
3034 accountable care organizations;

3035 (e) providers of physical or behavioral health services in the county who provide
3036 services to enrollees in the targeted adult Medicaid program in the county; and

3037 (f) other individuals that the department deems necessary.

3038 (5) If the department provides Medicaid coverage through a managed care delivery
3039 system under this section, the department shall include language in the department's managed
3040 care contracts that require the managed care plan to:

3041 (a) be in compliance with federal Medicaid managed care requirements;

3042 (b) timely and accurately process authorizations and claims in accordance with
3043 Medicaid policy and contract requirements;

3044 (c) adequately reimburse providers to maintain adequacy of access to care;

3045 (d) provide care management services sufficient to meet the needs of Medicaid eligible
3046 individuals enrolled in the managed care plan's plan; and

3047 (e) timely resolve any disputes between a provider or enrollee with the managed care
3048 plan.

3049 (6) The department may take corrective action if the managed care organization fails to
3050 comply with the terms of the managed care organization's contract.

3051 Section 65. Section **26B-3-224**, which is renumbered from Section 26-18-429 is
3052 renumbered and amended to read:

3080 dispensing, and patient usage, that it is in conformity with the criteria and standards developed
3081 in accordance with this part.

3082 (2) "Board" means the Drug Utilization Review Board created in Section [~~26-18-102~~]
3083 [26B-3-302](#).

3084 (3) "Certified program" means a nursing care facility program with Medicaid
3085 certification.

3086 [~~3~~] (4) "Compendia" means resources widely accepted by the medical profession in
3087 the efficacious use of drugs, including "American Hospital Formulary [~~Services~~] Service Drug
3088 Information," "U.S. Pharmacopeia - Drug Information," "A.M.A. Drug Evaluations,"
3089 peer-reviewed medical literature, and information provided by manufacturers of drug products.

3090 [~~4~~] (5) "Counseling" means the activities conducted by a pharmacist to inform
3091 Medicaid recipients about the proper use of drugs, as required by the board under this part.

3092 [~~5~~] (6) "Criteria" means those predetermined and explicitly accepted elements used to
3093 measure drug use on an ongoing basis in order to determine if the use is appropriate, medically
3094 necessary, and not likely to result in adverse medical outcomes.

3095 [~~6~~] (7) "Drug-disease contraindications" means that the therapeutic effect of a drug is
3096 adversely altered by the presence of another disease condition.

3097 [~~7~~] (8) "Drug-interactions" means that two or more drugs taken by a recipient lead to
3098 clinically significant toxicity that is characteristic of one or any of the drugs present, or that
3099 leads to interference with the effectiveness of one or any of the drugs.

3100 [~~8~~] (9) "Drug Utilization Review" or "DUR" means the program designed to measure
3101 and assess, on a retrospective and prospective basis, the proper use of outpatient drugs in the
3102 Medicaid program.

3103 [~~9~~] (10) "Intervention" means a form of communication utilized by the board with a
3104 prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

3105 (11) "Medicaid certification" means the right of a nursing care facility, as a provider of
3106 a nursing care facility program, to receive Medicaid reimbursement for a specified number of

3107 beds within the facility.

3108 (12) (a) "Nursing care facility" means the following facilities licensed by the
3109 department under Chapter 2, Part 2, Health Care Facility Licensing and Inspection:

3110 (i) skilled nursing facilities;

3111 (ii) intermediate care facilities; and

3112 (iii) an intermediate care facility for people with an intellectual disability.

3113 (b) "Nursing care facility" does not mean a critical access hospital that meets the
3114 criteria of 42 U.S.C. Sec. 1395i-4(c)(2) (1998).

3115 (13) "Nursing care facility program" means the personnel, licenses, services, contracts,
3116 and all other requirements that shall be met for a nursing care facility to be eligible for
3117 Medicaid certification under this part and division rule.

3118 ~~[(10)]~~ (14) "Overutilization" or "underutilization" means the use of a drug in such
3119 quantities that the desired therapeutic goal is not achieved.

3120 ~~[(11)]~~ (15) "Pharmacist" means a person licensed in this state to engage in the practice
3121 of pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act.

3122 (16) "Physical facility" means the buildings or other physical structures where a
3123 nursing care facility program is operated.

3124 ~~[(12)]~~ (17) "Physician" means a person licensed in this state to practice medicine and
3125 surgery under Section 58-67-301 or osteopathic medicine under Section 58-68-301.

3126 ~~[(13)]~~ (18) "Prospective DUR" means that part of the drug utilization review program
3127 that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy
3128 problems based on explicit and predetermined criteria and standards.

3129 ~~[(14)]~~ (19) "Retrospective DUR" means that part of the drug utilization review
3130 program that assesses or measures drug use based on an historical review of drug use data
3131 against predetermined and explicit criteria and standards, on an ongoing basis with professional
3132 input.

3133 (20) "Rural county" means a county with a population of less than 50,000, as

3134 determined by:

3135 (a) the most recent official census or census estimate of the United States Bureau of the
3136 Census; or

3137 (b) the most recent population estimate for the county from the Utah Population
3138 Committee, if a population figure for the county is not available under Subsection (20)(a).

3139 (21) "Service area" means the boundaries of the distinct geographic area served by a
3140 certified program as determined by the division in accordance with this part and division rule.

3141 ~~[(15)]~~ (22) "Standards" means the acceptable range of deviation from the criteria that
3142 reflects local medical practice and that is tested on the Medicaid recipient database.

3143 ~~[(16)]~~ (23) "SURS" means the Surveillance Utilization Review System of the Medicaid
3144 program.

3145 ~~[(17)]~~ (24) "Therapeutic appropriateness" means drug prescribing and dispensing based
3146 on rational drug therapy that is consistent with criteria and standards.

3147 ~~[(18)]~~ (25) "Therapeutic duplication" means prescribing and dispensing the same drug
3148 or two or more drugs from the same therapeutic class where periods of drug administration
3149 overlap and where that practice is not medically indicated.

3150 (26) "Urban county" means a county that is not a rural county.

3151 Section 67. Section **26B-3-302**, which is renumbered from Section 26-18-102 is
3152 renumbered and amended to read:

3153 ~~[26-18-102].~~ **26B-3-302. DUR Board -- Creation and membership --**
3154 **Expenses.**

3155 (1) There is created a 12-member Drug Utilization Review Board responsible for
3156 implementation of a retrospective and prospective DUR program.

3157 (2) (a) Except as required by Subsection (2)(b), as terms of current board members
3158 expire, the executive director shall appoint each new member or reappointed member to a
3159 four-year term.

3160 (b) Notwithstanding the requirements of Subsection (2)(a), the executive director shall,

3161 at the time of appointment or reappointment, adjust the length of terms to ensure that the terms
3162 of board members are staggered so that approximately half of the board is appointed every two
3163 years.

3164 (c) Persons appointed to the board may be reappointed upon completion of their terms,
3165 but may not serve more than two consecutive terms.

3166 (d) The executive director shall provide for geographic balance in representation on the
3167 board.

3168 (3) When a vacancy occurs in the membership for any reason, the replacement shall be
3169 appointed for the unexpired term.

3170 (4) The membership shall be comprised of the following:

3171 (a) four physicians who are actively engaged in the practice of medicine or osteopathic
3172 medicine in this state, to be selected from a list of nominees provided by the Utah Medical
3173 Association;

3174 (b) one physician in this state who is actively engaged in academic medicine;

3175 (c) three pharmacists who are actively practicing in retail pharmacy in this state, to be
3176 selected from a list of nominees provided by the Utah Pharmaceutical Association;

3177 (d) one pharmacist who is actively engaged in academic pharmacy;

3178 (e) one person who shall represent consumers;

3179 (f) one person who shall represent pharmaceutical manufacturers, to be recommended
3180 by the Pharmaceutical Manufacturers Association; and

3181 (g) one dentist licensed to practice in this state under Title 58, Chapter 69, Dentist and
3182 Dental Hygienist Practice Act, who is actively engaged in the practice of dentistry, nominated
3183 by the Utah Dental Association.

3184 (5) Physician and pharmacist members of the board shall have expertise in clinically
3185 appropriate prescribing and dispensing of outpatient drugs.

3186 (6) The board shall elect a chair from among its members who shall serve a one-year
3187 term, and may serve consecutive terms.

3188 (7) A member may not receive compensation or benefits for the member's service, but
3189 may receive per diem and travel expenses in accordance with:

3190 (a) Section 63A-3-106;

3191 (b) Section 63A-3-107; and

3192 (c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and
3193 63A-3-107.

3194 Section 68. Section 26B-3-303, which is renumbered from Section 26-18-103 is
3195 renumbered and amended to read:

3196 ~~[26-18-103]~~. **26B-3-303. DUR Board -- Responsibilities.**

3197 The board shall:

3198 (1) develop rules necessary to carry out its responsibilities as defined in this part;

3199 (2) oversee the implementation of a Medicaid retrospective and prospective DUR
3200 program in accordance with this part, including responsibility for approving provisions of
3201 contractual agreements between the Medicaid program and any other entity that will process
3202 and review Medicaid drug claims and profiles for the DUR program in accordance with this
3203 part;

3204 (3) develop and apply predetermined criteria and standards to be used in retrospective
3205 and prospective DUR, ensuring that the criteria and standards are based on the compendia, and
3206 that they are developed with professional input, in a consensus fashion, with provisions for
3207 timely revision and assessment as necessary. The DUR standards developed by the board shall
3208 reflect the local practices of physicians in order to monitor:

3209 (a) therapeutic appropriateness;

3210 (b) overutilization or underutilization;

3211 (c) therapeutic duplication;

3212 (d) drug-disease contraindications;

3213 (e) drug-drug interactions;

3214 (f) incorrect drug dosage or duration of drug treatment; and

- 3215 (g) clinical abuse and misuse;
- 3216 (4) develop, select, apply, and assess interventions and remedial strategies for
3217 physicians, pharmacists, and recipients that are educational and not punitive in nature, in order
3218 to improve the quality of care;
- 3219 (5) disseminate information to physicians and pharmacists to ensure that they are aware
3220 of the board's duties and powers;
- 3221 (6) provide written, oral, or electronic reminders of patient-specific or drug-specific
3222 information, designed to ensure recipient, physician, and pharmacist confidentiality, and
3223 suggest changes in prescribing or dispensing practices designed to improve the quality of care;
- 3224 (7) utilize face-to-face discussions between experts in drug therapy and the prescriber
3225 or pharmacist who has been targeted for educational intervention;
- 3226 (8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;
- 3227 (9) create an educational program using data provided through DUR to provide active
3228 and ongoing educational outreach programs to improve prescribing and dispensing practices,
3229 either directly or by contract with other governmental or private entities;
- 3230 (10) provide a timely evaluation of intervention to determine if those interventions
3231 have improved the quality of care;
- 3232 (11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec.
3233 712;
- 3234 (12) develop a working agreement with related boards or agencies, including the State
3235 Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order
3236 to clarify areas of responsibility for each, where those areas may overlap;
- 3237 (13) establish a grievance process for physicians and pharmacists under this part, in
3238 accordance with Title 63G, Chapter 4, Administrative Procedures Act;
- 3239 (14) publish and disseminate educational information to physicians and pharmacists
3240 concerning the board and the DUR program, including information regarding:
- 3241 (a) identification and reduction of the frequency of patterns of fraud, abuse, gross

3242 overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and
3243 recipients;

3244 (b) potential or actual severe or adverse reactions to drugs;

3245 (c) therapeutic appropriateness;

3246 (d) overutilization or underutilization;

3247 (e) appropriate use of generics;

3248 (f) therapeutic duplication;

3249 (g) drug-disease contraindications;

3250 (h) drug-drug interactions;

3251 (i) incorrect drug dosage and duration of drug treatment;

3252 (j) drug allergy interactions; and

3253 (k) clinical abuse and misuse;

3254 (15) develop and publish, with the input of the State Board of Pharmacy, guidelines
3255 and standards to be used by pharmacists in counseling Medicaid recipients in accordance with
3256 this part. The guidelines shall ensure that the recipient may refuse counseling and that the
3257 refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling
3258 include:

3259 (a) the name and description of the medication;

3260 (b) administration, form, and duration of therapy;

3261 (c) special directions and precautions for use;

3262 (d) common severe side effects or interactions, and therapeutic interactions, and how to
3263 avoid those occurrences;

3264 (e) techniques for self-monitoring drug therapy;

3265 (f) proper storage;

3266 (g) prescription refill information; and

3267 (h) action to be taken in the event of a missed dose; and

3268 (16) establish procedures in cooperation with the State Board of Pharmacy for

3269 pharmacists to record information to be collected under this part. The recorded information
3270 shall include:

- 3271 (a) the name, address, age, and gender of the recipient;
- 3272 (b) individual history of the recipient where significant, including disease state, known
3273 allergies and drug reactions, and a comprehensive list of medications and relevant devices;
- 3274 (c) the pharmacist's comments on the individual's drug therapy;
- 3275 (d) name of prescriber; and
- 3276 (e) name of drug, dose, duration of therapy, and directions for use.

3277 Section 69. Section **26B-3-304**, which is renumbered from Section 26-18-104 is
3278 renumbered and amended to read:

3279 ~~[26-18-104]~~. **26B-3-304. Confidentiality of records.**

3280 (1) Information obtained under this part shall be treated as confidential or controlled
3281 information under Title 63G, Chapter 2, Government Records Access and Management Act.

3282 (2) The board shall establish procedures ~~[insuring]~~ ensuring that the information
3283 described in Subsection ~~[26-18-103]~~ 26B-3-304(16) is held confidential by the pharmacist,
3284 being provided to the physician only upon request.

3285 (3) The board shall adopt and implement procedures designed to ensure the
3286 confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the
3287 board, staff to the board, or contractors to the DUR program, that identifies individual
3288 physicians, pharmacists, or recipients. The board may have access to identifying information
3289 for purposes of carrying out intervention activities, but that identifying information may not be
3290 released to anyone other than a member of the board. The board may release cumulative
3291 nonidentifying information for research purposes.

3292 Section 70. Section **26B-3-305**, which is renumbered from Section 26-18-105 is
3293 renumbered and amended to read:

3294 ~~[26-18-105]~~. **26B-3-305. Drug prior approval program.**

3295 (1) A drug prior approval program approved or implemented by the board shall meet

3296 the following conditions:

3297 (a) except as provided in Subsection (2), a drug may not be placed on prior approval
3298 for other than medical reasons;

3299 (b) the board shall hold a public hearing at least 30 days prior to placing a drug on prior
3300 approval;

3301 (c) notwithstanding the provisions of Section 52-4-202, the board shall provide not less
3302 than 14 days' notice to the public before holding a public hearing under Subsection (1)(b);

3303 (d) the board shall consider written and oral comments submitted by interested parties
3304 prior to or during the hearing held in accordance with Subsection (1)(b);

3305 (e) the board shall provide evidence that placing a drug class on prior approval:

3306 (i) will not impede quality of recipient care; and

3307 (ii) that the drug class is subject to clinical abuse or misuse;

3308 (f) the board shall reconsider its decision to place a drug on prior approval:

3309 (i) no later than nine months after any drug class is placed on prior approval; and

3310 (ii) at a public hearing with notice as provided in Subsection (1)(b);

3311 (g) the program shall provide an approval or denial of a request for prior approval:

3312 (i) by either:

3313 (A) fax;

3314 (B) telephone; or

3315 (C) electronic transmission;

3316 (ii) at least Monday through Friday, except for state holidays; and

3317 (iii) within 24 hours after receipt of the prior approval request;

3318 (h) the program shall provide for the dispensing of at least a 72-hour supply of the drug
3319 on the prior approval program:

3320 (i) in an emergency situation; or

3321 (ii) on weekends or state holidays;

3322 (i) the program may be applied to allow acceptable medical use of a drug on prior

3323 approval for appropriate off-label indications; and

3324 (j) before placing a drug class on the prior approval program, the board shall:

3325 (i) determine that the requirements of Subsections (1)(a) through (i) have been met;

3326 and

3327 (ii) by majority vote, place the drug class on prior approval.

3328 (2) The board may, only after complying with Subsections (1)(b) through (j), consider
3329 the cost:

3330 (a) of a drug when placing a drug on the prior approval program; and

3331 (b) associated with including, or excluding a drug from the prior approval process,
3332 including:

3333 (i) potential side effects associated with a drug; or

3334 (ii) potential hospitalizations or other complications that may occur as a result of a
3335 drug's inclusion on the prior approval process.

3336 Section 71. Section **26B-3-306**, which is renumbered from Section 26-18-106 is
3337 renumbered and amended to read:

3338 ~~[26-18-106]~~. **26B-3-306**. **Advisory committees.**

3339 The board may establish advisory committees to assist it in carrying out its duties under
3340 ~~[this part]~~ Sections [26B-3-302](#) through [26B-3-309](#).

3341 Section 72. Section **26B-3-307**, which is renumbered from Section 26-18-107 is
3342 renumbered and amended to read:

3343 ~~[26-18-107]~~. **26B-3-307**. **Retrospective and prospective DUR.**

3344 (1) The board, in cooperation with the division, shall include in its state plan the
3345 creation and implementation of a retrospective and prospective DUR program for Medicaid
3346 outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely
3347 to result in adverse medical outcomes.

3348 (2) The retrospective and prospective DUR program shall be operated under guidelines
3349 established by the board under Subsections (3) and (4).

3350 (3) The retrospective DUR program shall be based on guidelines established by the
3351 board, using the mechanized drug claims processing and information retrieval system to
3352 analyze claims data in order to:

3353 (a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically
3354 unnecessary care; and

3355 (b) assess data on drug use against explicit predetermined standards that are based on
3356 the compendia and other sources for the purpose of monitoring:

3357 (i) therapeutic appropriateness;

3358 (ii) overutilization or underutilization;

3359 (iii) therapeutic duplication;

3360 (iv) drug-disease contraindications;

3361 (v) drug-drug interactions;

3362 (vi) incorrect drug dosage or duration of drug treatment; and

3363 (vii) clinical abuse and misuse.

3364 (4) The prospective DUR program shall be based on guidelines established by the
3365 board and shall provide that, before a prescription is filled or delivered, a review will be
3366 conducted by the pharmacist at the point of sale to screen for potential drug therapy problems
3367 resulting from:

3368 (a) therapeutic duplication;

3369 (b) drug-drug interactions;

3370 (c) incorrect dosage or duration of treatment;

3371 (d) drug-allergy interactions; and

3372 (e) clinical abuse or misuse.

3373 (5) In conducting the prospective DUR, a pharmacist may not alter the prescribed
3374 outpatient drug therapy without the consent of the prescribing physician or physician assistant.

3375 This section does not effect the ability of a pharmacist to substitute a generic equivalent.

3376 Section 73. Section **26B-3-308**, which is renumbered from Section 26-18-108 is

3377 renumbered and amended to read:

3378 ~~[26-18-108]~~. **26B-3-308. Penalties.**

3379 Any person who violates the confidentiality provisions of ~~[this part]~~ Sections
3380 26B-3-302 through 26B-3-307 is guilty of a class B misdemeanor.

3381 Section 74. Section **26B-3-309**, which is renumbered from Section 26-18-109 is
3382 renumbered and amended to read:

3383 ~~[26-18-109]~~. **26B-3-309. Immunity.**

3384 There is no liability on the part of, and no cause of action of any nature arises against
3385 any member of the board, its agents, or employees for any action or omission by them in
3386 effecting the provisions of ~~[this part]~~ Sections 26B-3-302 through 26B-3-307.

3387 Section 75. Section **26B-3-310**, which is renumbered from Section 26-18-502 is
3388 renumbered and amended to read:

3389 ~~[26-18-502]~~. **26B-3-310. Purpose -- Medicaid certification of nursing care**
3390 **facilities.**

3391 (1) The Legislature finds:

3392 (a) that an oversupply of nursing care facilities in the state adversely affects the state
3393 Medicaid program and the health of the people in the state;

3394 (b) it is in the best interest of the state to prohibit nursing care facilities from receiving
3395 Medicaid certification, except as provided by ~~[this part]~~ Sections 26B-3-311 through
3396 26B-3-313; and

3397 (c) it is in the best interest of the state to encourage aging nursing care facilities with
3398 Medicaid certification to renovate the nursing care facilities' physical facilities so that the
3399 quality of life and clinical services for Medicaid residents are preserved.

3400 (2) Medicaid reimbursement of nursing care facility programs is limited to:

3401 (a) the number of nursing care facility programs with Medicaid certification as of May
3402 9, 2016; and

3403 (b) additional nursing care facility programs approved for Medicaid certification under

3404 the provisions of Subsections [~~26-18-503~~] 26B-3-311(5) and (7).

3405 (3) The division may not:

3406 (a) except as authorized by Section [~~26-18-503~~] 26B-3-311:

3407 (i) process initial applications for Medicaid certification or execute provider
3408 agreements with nursing care facility programs; or

3409 (ii) reinstate Medicaid certification for a nursing care facility whose certification
3410 expired or was terminated by action of the federal or state government; or

3411 (b) execute a Medicaid provider agreement with a certified program that moves to a
3412 different physical facility, except as authorized by Subsection [~~26-18-503~~] 26B-3-311(3).

3413 (4) Notwithstanding Section [~~26-18-503~~] 26B-3-311, beginning May 4, 2021, the
3414 division may not approve a new or additional bed in an intermediate care facility for
3415 individuals with an intellectual disability for Medicaid certification, unless certification of the
3416 bed by the division does not increase the total number in the state of Medicaid-certified beds in
3417 intermediate care facilities for individuals with an intellectual disability.

3418 Section 76. Section **26B-3-311**, which is renumbered from Section 26-18-503 is
3419 renumbered and amended to read:

3420 [~~26-18-503~~]. **26B-3-311. Authorization to renew, transfer, or increase**
3421 **Medicaid certified programs -- Reimbursement methodology.**

3422 (1) (a) The division may renew Medicaid certification of a certified program if the
3423 program, without lapse in service to Medicaid recipients, has its nursing care facility program
3424 certified by the division at the same physical facility as long as the licensed and certified bed
3425 capacity at the facility has not been expanded, unless the director has approved additional beds
3426 in accordance with Subsection (5).

3427 (b) The division may renew Medicaid certification of a nursing care facility program
3428 that is not currently certified if:

3429 (i) since the day on which the program last operated with Medicaid certification:

3430 (A) the physical facility where the program operated has functioned solely and

3431 continuously as a nursing care facility; and

3432 (B) the owner of the program has not, under this section or Section [~~26-18-505~~]
3433 26B-3-313, transferred to another nursing care facility program the license for any of the
3434 Medicaid beds in the program; and

3435 (ii) except as provided in Subsection [~~26-18-502~~] 26B-3-310(4), the number of beds
3436 granted renewed Medicaid certification does not exceed the number of beds certified at the
3437 time the program last operated with Medicaid certification, excluding a period of time where
3438 the program operated with temporary certification under Subsection [~~26-18-504~~] 26B-3-312(3).

3439 (2) (a) The division may issue a Medicaid certification for a new nursing care facility
3440 program if a current owner of the Medicaid certified program transfers its ownership of the
3441 Medicaid certification to the new nursing care facility program and the new nursing care
3442 facility program meets all of the following conditions:

3443 (i) the new nursing care facility program operates at the same physical facility as the
3444 previous Medicaid certified program;

3445 (ii) the new nursing care facility program gives a written assurance to the director in
3446 accordance with Subsection (4);

3447 (iii) the new nursing care facility program receives the Medicaid certification within
3448 one year of the date the previously certified program ceased to provide medical assistance to a
3449 Medicaid recipient; and

3450 (iv) the licensed and certified bed capacity at the facility has not been expanded, unless
3451 the director has approved additional beds in accordance with Subsection (5).

3452 (b) A nursing care facility program that receives Medicaid certification under the
3453 provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing
3454 care facility program if the new nursing care facility program:

3455 (i) is not owned in whole or in part by the previous nursing care facility program; or

3456 (ii) is not a successor in interest of the previous nursing care facility program.

3457 (3) The division may issue a Medicaid certification to a nursing care facility program

3458 that was previously a certified program but now resides in a new or renovated physical facility
3459 if the nursing care facility program meets all of the following:

3460 (a) the nursing care facility program met all applicable requirements for Medicaid
3461 certification at the time of closure;

3462 (b) the new or renovated physical facility is in the same county or within a five-mile
3463 radius of the original physical facility;

3464 (c) the time between which the certified program ceased to operate in the original
3465 facility and will begin to operate in the new physical facility is not more than three years,
3466 unless:

3467 (i) an emergency is declared by the president of the United States or the governor,
3468 affecting the building or renovation of the physical facility;

3469 (ii) the director approves an exception to the three-year requirement for any nursing
3470 care facility program within the three-year requirement;

3471 (iii) the provider submits documentation supporting a request for an extension to the
3472 director that demonstrates a need for an extension; and

3473 (iv) the exception does not extend for more than two years beyond the three-year
3474 requirement;

3475 (d) if Subsection (3)(c) applies, the certified program notifies the department within 90
3476 days after ceasing operations in its original facility, of its intent to retain its Medicaid
3477 certification;

3478 (e) the provider gives written assurance to the director in accordance with Subsection
3479 (4) that no third party has a legitimate claim to operate a certified program at the previous
3480 physical facility; and

3481 (f) the bed capacity in the physical facility has not been expanded unless the director
3482 has approved additional beds in accordance with Subsection (5).

3483 (4) (a) The entity requesting Medicaid certification under Subsections (2) and (3) shall
3484 give written assurances satisfactory to the director or the director's designee that:

3485 (i) no third party has a legitimate claim to operate the certified program;
3486 (ii) the requesting entity agrees to defend and indemnify the department against any
3487 claims by a third party who may assert a right to operate the certified program; and
3488 (iii) if a third party is found, by final agency action of the department after exhaustion
3489 of all administrative and judicial appeal rights, to be entitled to operate a certified program at
3490 the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

3491 (b) If a finding is made under the provisions of Subsection (4)(a)(iii):

3492 (i) the certified program shall immediately surrender its Medicaid certification and
3493 comply with division rules regarding billing for Medicaid and the provision of services to
3494 Medicaid patients; and

3495 (ii) the department shall transfer the surrendered Medicaid certification to the third
3496 party who prevailed under Subsection (4)(a)(iii).

3497 (5) (a) The director may approve additional nursing care facility programs for Medicaid
3498 certification, or additional beds for Medicaid certification within an existing nursing care
3499 facility program, if a nursing care facility or other interested party requests Medicaid
3500 certification for a nursing care facility program or additional beds within an existing nursing
3501 care facility program, and the nursing care facility program or other interested party complies
3502 with this section.

3503 (b) The nursing care facility or other interested party requesting Medicaid certification
3504 for a nursing care facility program or additional beds within an existing nursing care facility
3505 program under Subsection (5)(a) shall submit to the director:

3506 (i) proof of the following as reasonable evidence that bed capacity provided by
3507 Medicaid certified programs within the county or group of counties impacted by the requested
3508 additional Medicaid certification is insufficient:

3509 (A) nursing care facility occupancy levels for all existing and proposed facilities will
3510 be at least 90% for the next three years;

3511 (B) current nursing care facility occupancy is 90% or more; or

3512 (C) there is no other nursing care facility within a 35-mile radius of the nursing care
3513 facility requesting the additional certification; and

3514 (ii) an independent analysis demonstrating that at projected occupancy rates the nursing
3515 care facility's after-tax net income is sufficient for the facility to be financially viable.

3516 (c) Any request for additional beds as part of a renovation project are limited to the
3517 maximum number of beds allowed in Subsection (7).

3518 (d) The director shall determine whether to issue additional Medicaid certification by
3519 considering:

3520 (i) whether bed capacity provided by certified programs within the county or group of
3521 counties impacted by the requested additional Medicaid certification is insufficient, based on
3522 the information submitted to the director under Subsection (5)(b);

3523 (ii) whether the county or group of counties impacted by the requested additional
3524 Medicaid certification is underserved by specialized or unique services that would be provided
3525 by the nursing care facility;

3526 (iii) whether any Medicaid certified beds are subject to a claim by a previous certified
3527 program that may reopen under the provisions of Subsections (2) and (3);

3528 (iv) how additional bed capacity should be added to the long-term care delivery system
3529 to best meet the needs of Medicaid recipients; and

3530 (v) (A) whether the existing certified programs within the county or group of counties
3531 have provided services of sufficient quality to merit at least a two-star rating in the Medicare
3532 Five-Star Quality Rating System over the previous three-year period; and

3533 (B) information obtained under Subsection (9).

3534 (6) The department shall adopt administrative rules in accordance with Title 63G,
3535 Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility
3536 property reimbursement methodology to:

3537 (a) only pay that portion of the property component of rates, representing actual bed
3538 usage by Medicaid clients as a percentage of the greater of:

3539 (i) actual occupancy; or
3540 (ii) (A) for a nursing care facility other than a facility described in Subsection
3541 (6)(a)(ii)(B), 85% of total bed capacity; or
3542 (B) for a rural nursing care facility, 65% of total bed capacity; and
3543 (b) not allow for increases in reimbursement for property values without major
3544 renovation or replacement projects as defined by the department by rule.
3545 (7) (a) Except as provided in Subsection ~~[26-18-502(3)]~~ 26B-3-310(3), if a nursing
3546 care facility does not seek Medicaid certification for a bed under Subsections (1) through (6),
3547 the department shall, notwithstanding Subsections ~~[26-18-504]~~ 26B-3-312(3)(a) and (b), grant
3548 Medicaid certification for additional beds in an existing Medicaid certified nursing care facility
3549 that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility if:
3550 (i) the nursing care facility program was previously a certified program for all beds but
3551 now resides in a new facility or in a facility that underwent major renovations involving major
3552 structural changes, with 50% or greater facility square footage design changes, requiring review
3553 and approval by the department;
3554 (ii) the nursing care facility meets the quality of care regulations issued by CMS; and
3555 (iii) the total number of additional beds in the facility granted Medicaid certification
3556 under this section does not exceed 10% of the number of licensed beds in the facility.
3557 (b) The department may not revoke the Medicaid certification of a bed under this
3558 Subsection (7) as long as the provisions of Subsection (7)(a)(ii) are met.
3559 (8) (a) If a nursing care facility or other interested party indicates in its request for
3560 additional Medicaid certification under Subsection (5)(a) that the facility will offer specialized
3561 or unique services, but the facility does not offer those services after receiving additional
3562 Medicaid certification, the director shall revoke the additional Medicaid certification.
3563 (b) The nursing care facility program shall obtain Medicaid certification for any
3564 additional Medicaid beds approved under Subsection (5) or (7) within three years of the date of
3565 the director's approval, or the approval is void.

3566 (9) (a) If the director makes an initial determination that quality standards under
 3567 Subsection (5)(d)(v) have not been met in a rural county or group of rural counties over the
 3568 previous three-year period, the director shall, before approving certification of additional
 3569 Medicaid beds in the rural county or group of counties:

3570 (i) notify the certified program that has not met the quality standards in Subsection
 3571 (5)(d)(v) that the director intends to certify additional Medicaid beds under the provisions of
 3572 Subsection (5)(d)(v); and

3573 (ii) consider additional information submitted to the director by the certified program
 3574 in a rural county that has not met the quality standards under Subsection (5)(d)(v).

3575 (b) The notice under Subsection (9)(a) does not give the certified program that has not
 3576 met the quality standards under Subsection (5)(d)(v), the right to legally challenge or appeal the
 3577 director's decision to certify additional Medicaid beds under Subsection (5)(d)(v).

3578 Section 77. Section **26B-3-312**, which is renumbered from Section 26-18-504 is
 3579 renumbered and amended to read:

3580 ~~[26-18-504]~~. **26B-3-312. Appeals of division decision -- Rulemaking**
 3581 **authority -- Application of act.**

3582 (1) A decision by the director under this part to deny Medicaid certification for a
 3583 nursing care facility program or to deny additional bed capacity for an existing certified
 3584 program is subject to review under the procedures and requirements of Title 63G, Chapter 4,
 3585 Administrative Procedures Act.

3586 (2) The department shall make rules to administer and enforce ~~[this part]~~ Sections
 3587 26B-3-310 through 26B-3-313 in accordance with Title 63G, Chapter 3, Utah Administrative
 3588 Rulemaking Act.

3589 (3) (a) In the event the department is at risk for a federal disallowance with regard to a
 3590 Medicaid recipient being served in a nursing care facility program that is not Medicaid
 3591 certified, the department may grant temporary Medicaid certification to that facility for up to 24
 3592 months.

3593 (b) (i) The department may extend a temporary Medicaid certification granted to a
3594 facility under Subsection (3)(a):

3595 (A) for the number of beds in the nursing care facility occupied by a Medicaid
3596 recipient; and

3597 (B) for the period of time during which the Medicaid recipient resides at the facility.

3598 (ii) A temporary Medicaid certification granted under this Subsection (3) is revoked
3599 upon:

3600 (A) the discharge of the patient from the facility; or

3601 (B) the patient no longer residing at the facility for any reason.

3602 (c) The department may place conditions on the temporary certification granted under
3603 Subsections (3)(a) and (b), such as:

3604 (i) not allowing additional admissions of Medicaid recipients to the program; and

3605 (ii) not paying for the care of the patient after October 1, 2008, with state only dollars.

3606 Section 78. Section **26B-3-313**, which is renumbered from Section 26-18-505 is
3607 renumbered and amended to read:

3608 ~~[26-18-505]~~. **26B-3-313**. **Authorization to sell or transfer licensed**

3609 **Medicaid beds -- Duties of transferor -- Duties of transferee -- Duties of division.**

3610 (1) This section provides a method to transfer or sell the license for a Medicaid bed
3611 from a nursing care facility program to another entity that is in addition to the authorization to
3612 transfer under Section ~~[26-18-503]~~ [26B-3-311](#).

3613 (2) (a) A nursing care facility program may transfer or sell one or more of its licenses
3614 for Medicaid beds in accordance with Subsection (2)(b) if:

3615 (i) at the time of the transfer, and with respect to the license for the Medicaid bed that
3616 will be transferred, the nursing care facility program that will transfer the Medicaid license
3617 meets all applicable regulations for Medicaid certification;

3618 (ii) the nursing care facility program gives a written assurance, which is postmarked or
3619 has proof of delivery 30 days before the transfer, to the director and to the transferee in

3620 accordance with Subsection [~~26-18-503~~] 26B-3-311(4);

3621 (iii) the nursing care facility program that will transfer the license for a Medicaid bed
3622 notifies the division in writing, which is postmarked or has proof of delivery 30 days before the
3623 transfer, of:

3624 (A) the number of bed licenses that will be transferred;

3625 (B) the date of the transfer; and

3626 (C) the identity and location of the entity receiving the transferred licenses; and

3627 (iv) if the nursing care facility program for which the license will be transferred or
3628 purchased is located in an urban county with a nursing care facility average annual occupancy
3629 rate over the previous two years less than or equal to 75%, the nursing care facility program
3630 transferring or selling the license demonstrates to the satisfaction of the director that the sale or
3631 transfer:

3632 (A) will not result in an excessive number of Medicaid certified beds within the county
3633 or group of counties that would be impacted by the transfer or sale; and

3634 (B) best meets the needs of Medicaid recipients.

3635 (b) Except as provided in Subsection (2)(c), a nursing care facility program may
3636 transfer or sell one or more of its licenses for Medicaid beds to:

3637 (i) a nursing care facility program that has the same owner or successor in interest of
3638 the same owner;

3639 (ii) a nursing care facility program that has a different owner; or

3640 (iii) a related-party nonnursing-care-facility entity that wants to hold one or more of the
3641 licenses for a nursing care facility program not yet identified, as long as:

3642 (A) the licenses are subsequently transferred or sold to a nursing care facility program
3643 within three years; and

3644 (B) the nursing care facility program notifies the director of the transfer or sale in
3645 accordance with Subsection (2)(a)(iii).

3646 (c) A nursing care facility program may not transfer or sell one or more of its licenses

3647 for Medicaid beds to an entity under Subsection (2)(b)(i), (ii), or (iii) that is located in a rural
3648 county unless the entity requests, and the director issues, Medicaid certification for the beds
3649 under Subsection [~~26-18-503~~] 26B-3-311(5).

3650 (3) A nursing care facility program or entity under Subsection (2)(b)(i), (ii), or (iii) that
3651 receives or purchases a license for a Medicaid bed under Subsection (2)(b):

3652 (a) may receive a license for a Medicaid bed from more than one nursing care facility
3653 program;

3654 (b) shall give the division notice, which is postmarked or has proof of delivery within
3655 14 days of the nursing care facility program or entity seeking Medicaid certification of beds in
3656 the nursing care facility program or entity, of the total number of licenses for Medicaid beds
3657 that the entity received and who it received the licenses from;

3658 (c) may only seek Medicaid certification for the number of licensed beds in the nursing
3659 care facility program equal to the total number of licenses for Medicaid beds received by the
3660 entity;

3661 (d) does not have to demonstrate need or seek approval for the Medicaid licensed bed
3662 under Subsection [~~26-18-503~~] 26B-3-311(5), except as provided in Subsections (2)(a)(iv) and
3663 (2)(c);

3664 (e) shall meet the standards for Medicaid certification other than those in Subsection
3665 [~~26-18-503~~] 26B-3-311(5), including personnel, services, contracts, and licensing of facilities
3666 under [~~Chapter 21, Health Care Facility Licensing and Inspection Act~~] Chapter 2, Part 2,
3667 Health Care Facility Licensing and Inspection; and

3668 (f) shall obtain Medicaid certification for the licensed Medicaid beds within three years
3669 of the date of transfer as documented under Subsection (2)(a)(iii)(B).

3670 (4) (a) When the division receives notice of a transfer of a license for a Medicaid bed
3671 under Subsection (2)(a)(iii)(A), the department shall reduce the number of licenses for
3672 Medicaid beds at the transferring nursing care facility:

3673 (i) equal to the number of licenses transferred; and

3674 (ii) effective on the date of the transfer as reported under Subsection (2)(a)(iii)(B).

3675 (b) For purposes of Section [~~26-18-502~~] 26B-3-310, the division shall approve

3676 Medicaid certification for the receiving nursing care facility program or entity:

3677 (i) in accordance with the formula established in Subsection (3)(c); and

3678 (ii) if:

3679 (A) the nursing care facility seeks Medicaid certification for the transferred licenses
3680 within the time limit required by Subsection (3)(f); and

3681 (B) the nursing care facility program meets other requirements for Medicaid
3682 certification under Subsection (3)(e).

3683 (c) A license for a Medicaid bed may not be approved for Medicaid certification
3684 without meeting the requirements of Sections [~~26-18-502 and 26-18-503~~] 26B-3-310 and
3685 26B-3-311 if:

3686 (i) the license for a Medicaid bed is transferred under this section but the receiving
3687 entity does not obtain Medicaid certification for the licensed bed within the time required by
3688 Subsection (3)(f); or

3689 (ii) the license for a Medicaid bed is transferred under this section but the license is no
3690 longer eligible for Medicaid certification.

3691 Section 79. Section **26B-3-401**, which is renumbered from Section 26-35a-103 is
3692 renumbered and amended to read:

3693 **Part 4. Nursing Care Facility Assessment**

3694 [~~26-35a-103~~]. **26B-3-401. Definitions.**

3695 As used in this [chapter] part:

3696 (1) (a) "Nursing care facility" means:

3697 (i) a nursing care facility [~~described in Subsection 26-21-2(17)~~] as defined in Section
3698 26B-2-201;

3699 (ii) beginning January 1, 2006, a designated swing bed in:

3700 (A) a general acute hospital as defined in [~~Subsection 26-21-2(11)~~] Section 26B-2-201;

3701 and

3702 (B) a critical access hospital which meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2)
3703 (1998); and

3704 (iii) an intermediate care facility for people with an intellectual disability that is
3705 licensed under Section ~~[26-21-13.5]~~ 26B-2-212.

3706 (b) "Nursing care facility" does not include:

3707 (i) the Utah State Developmental Center;

3708 (ii) the Utah State Hospital;

3709 (iii) a general acute hospital, specialty hospital, or small health care facility as those
3710 terms are defined in Section ~~[26-21-2]~~ 26B-2-201; or

3711 (iv) a Utah State Veterans Home.

3712 (2) "Patient day" means each calendar day in which an individual patient is admitted to
3713 the nursing care facility during a calendar month, even if on a temporary leave of absence from
3714 the facility.

3715 Section 80. Section **26B-3-402**, which is renumbered from Section 26-35a-102 is
3716 renumbered and amended to read:

3717 ~~[26-35a-102]~~. **26B-3-402. Legislative findings.**

3718 (1) The Legislature finds that there is an important state purpose to improve the quality
3719 of care given to persons who are elderly and to people who have a disability, in long-term care
3720 nursing facilities.

3721 (2) The Legislature finds that in order to improve the quality of care to those persons
3722 described in Subsection (1), the rates paid to the nursing care facilities by the Medicaid
3723 program must be adequate to encourage and support quality care.

3724 (3) The Legislature finds that in order to meet the objectives in Subsections (1) and (2),
3725 adequate funding must be provided to increase the rates paid to nursing care facilities providing
3726 services pursuant to the Medicaid program.

3727 Section 81. Section **26B-3-403**, which is renumbered from Section 26-35a-104 is

3728 renumbered and amended to read:

3729 ~~[26-35a-104]~~. 26B-3-403. Collection, remittance, and payment of nursing
3730 **care facilities assessment.**

3731 (1) (a) Beginning July 1, 2004, an assessment is imposed upon each nursing care
3732 facility in the amount designated in Subsection (1)(c).

3733 (b) (i) The department shall establish by rule, a uniform rate per non-Medicare patient
3734 day that may not exceed 6% of the total gross revenue for services provided to patients of all
3735 nursing care facilities licensed in this state.

3736 (ii) For purposes of Subsection (1)(b)(i), total revenue does not include charitable
3737 contribution received by a nursing care facility.

3738 (c) The department shall calculate the assessment imposed under Subsection (1)(a) by
3739 multiplying the total number of patient days of care provided to non-Medicare patients by the
3740 nursing care facility, as provided to the department pursuant to Subsection (3)(a), by the
3741 uniform rate established by the department pursuant to Subsection (1)(b).

3742 (2) (a) The assessment imposed by this ~~[chapter]~~ part is due and payable on a monthly
3743 basis on or before the last day of the month next succeeding each monthly period.

3744 (b) The collecting agent for this assessment shall be the department which is vested
3745 with the administration and enforcement of this ~~[chapter]~~ part, including the right to audit
3746 records of a nursing care facility related to patient days of care for the facility.

3747 (c) The department shall forward proceeds from the assessment imposed by this
3748 ~~[chapter]~~ part to the state treasurer for deposit in the expendable special revenue fund as
3749 specified in Section ~~[26-35a-106]~~ 26B-1-332.

3750 (3) Each nursing care facility shall, on or before the end of the month next succeeding
3751 each calendar monthly period, file with the department:

3752 (a) a report which includes:

3753 (i) the total number of patient days of care the facility provided to non-Medicare
3754 patients during the preceding month;

3755 (ii) the total gross revenue the facility earned as compensation for services provided to
3756 patients during the preceding month; and

3757 (iii) any other information required by the department; and

3758 (b) a return for the monthly period, and shall remit with the return the assessment
3759 required by this ~~[chapter]~~ part to be paid for the period covered by the return.

3760 (4) Each return shall contain information and be in the form the department prescribes
3761 by rule.

3762 (5) The assessment as computed in the return is an allowable cost for Medicaid
3763 reimbursement purposes.

3764 (6) The department may by rule, extend the time for making returns and paying the
3765 assessment.

3766 (7) Each nursing care facility that fails to pay any assessment required to be paid to the
3767 state, within the time required by this ~~[chapter]~~ part, or that fails to file a return as required by
3768 this ~~[chapter]~~ part, shall pay, in addition to the assessment, penalties and interest as provided in
3769 Section ~~[26-35a-105]~~ 26B-3-404.

3770 Section 82. Section **26B-3-404**, which is renumbered from Section 26-35a-105 is
3771 renumbered and amended to read:

3772 ~~[26-35a-105]~~. **26B-3-404. Penalties and interest.**

3773 (1) The penalty for failure to file a return or pay the assessment due within the time
3774 prescribed by this ~~[chapter]~~ part is the greater of \$50, or 1% of the assessment due on the
3775 return.

3776 (2) For failure to pay within 30 days of a notice of deficiency of assessment required to
3777 be paid, the penalty is the greater of \$50 or 5% of the assessment due.

3778 (3) The penalty for underpayment of the assessment is as follows:

3779 (a) If any underpayment of assessment is due to negligence, the penalty is 25% of the
3780 underpayment.

3781 (b) If the underpayment of the assessment is due to intentional disregard of law or rule,

3782 the penalty is 50% of the underpayment.

3783 (4) For intent to evade the assessment, the penalty is 100% of the underpayment.

3784 (5) The rate of interest applicable to an underpayment of an assessment under this
3785 [~~chapter~~] part or an unpaid penalty under this [~~chapter~~] part is 12% annually.

3786 (6) The department may waive the imposition of a penalty for good cause.

3787 Section 83. Section **26B-3-405**, which is renumbered from Section 26-35a-107 is
3788 renumbered and amended to read:

3789 ~~[26-35a-107]~~. **26B-3-405. Adjustment to nursing care facility Medicaid**
3790 **reimbursement rates.**

3791 If federal law or regulation prohibits the money in the Nursing Care Facilities Provider
3792 Assessment Fund from being used in the manner set forth in Subsection ~~[26-35a-106]~~
3793 26B-1-332(1)(b), the rates paid to nursing care facilities for providing services pursuant to the
3794 Medicaid program shall be changed:

3795 (1) except as otherwise provided in Subsection (2), to the rates paid to nursing care
3796 facilities on June 30, 2004; or

3797 (2) if the Legislature or the department has on or after July 1, 2004, changed the rates
3798 paid to facilities through a manner other than the use of expenditures from the Nursing Care
3799 Facilities Provider Assessment Fund, to the rates provided for by the Legislature or the
3800 department.

3801 Section 84. Section **26B-3-406**, which is renumbered from Section 26-35a-108 is
3802 renumbered and amended to read:

3803 ~~[26-35a-108]~~. **26B-3-406. Intermediate care facility for people with an**
3804 **intellectual disability -- Uniform rate.**

3805 An intermediate care facility for people with an intellectual disability is subject to all
3806 the provisions of this [~~chapter~~] part, except that the department shall establish a uniform rate
3807 for an intermediate care facility for people with an intellectual disability that:

3808 (1) is based on the same formula specified for nursing care facilities under the

3809 provisions of Subsection [~~26-35a-104~~] [26B-3-403](#)(1)(b); and
3810 (2) may be different than the uniform rate established for other nursing care facilities.

3811 Section 85. Section **26B-3-501**, which is renumbered from Section 26-36b-103 is
3812 renumbered and amended to read:

3813 **Part 5. Inpatient Hospital Assessment**

3814 [~~26-36b-103~~]. **26B-3-501. Definitions.**

3815 As used in this [~~chapter~~] part:

3816 (1) "Assessment" means the inpatient hospital assessment established by this [~~chapter~~]
3817 part.

3818 (2) "CMS" means the Centers for Medicare and Medicaid Services within the United
3819 States Department of Health and Human Services.

3820 (3) "Discharges" means the number of total hospital discharges reported on:

3821 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost
3822 report for the applicable assessment year; or

3823 (b) a similar report adopted by the department by administrative rule, if the report
3824 under Subsection (3)(a) is no longer available.

3825 (4) "Division" means the Division of [~~Health Care Financing~~] Integrated Healthcare
3826 within the department.

3827 (5) "Enhancement waiver program" means the program established by the Primary
3828 Care Network enhancement waiver program described in Section [~~26-18-416~~] [26B-3-211](#).

3829 (6) "Health coverage improvement program" means the health coverage improvement
3830 program described in Section [~~26-18-411~~] [26B-3-207](#).

3831 (7) "Hospital share" means the hospital share described in Section [~~26-36b-203~~]
3832 [26B-3-505](#).

3833 (8) "Medicaid accountable care organization" means a managed care organization, as
3834 defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of
3835 Section [~~26-18-405~~] [26B-3-202](#).

3836 (9) "Medicaid waiver expansion" means a Medicaid expansion in accordance with
3837 Section [~~26-18-3-9 or 26-18-415~~] [26B-3-113](#) or [26B-3-210](#).

3838 (10) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing
3839 of hospitals.

3840 (11) (a) "Non-state government hospital" means a hospital owned by a non-state
3841 government entity.

3842 (b) "Non-state government hospital" does not include:

3843 (i) the Utah State Hospital; or

3844 (ii) a hospital owned by the federal government, including the Veterans Administration
3845 Hospital.

3846 (12) (a) "Private hospital" means:

3847 (i) a general acute hospital, as defined in Section [~~26-21-2~~] [26B-2-201](#), that is privately
3848 owned and operating in the state; and

3849 (ii) a privately owned specialty hospital operating in the state, including a privately
3850 owned hospital whose inpatient admissions are predominantly for:

3851 (A) rehabilitation;

3852 (B) psychiatric care;

3853 (C) chemical dependency services; or

3854 (D) long-term acute care services.

3855 (b) "Private hospital" does not include a facility for residential treatment as defined in
3856 Section [~~62A-2-101~~] [26B-2-101](#).

3857 (13) "State teaching hospital" means a state owned teaching hospital that is part of an
3858 institution of higher education.

3859 (14) "Upper payment limit gap" means the difference between the private hospital
3860 outpatient upper payment limit and the private hospital Medicaid outpatient payments, as
3861 determined in accordance with 42 C.F.R. Sec. 447.321.

3862 Section 86. Section **26B-3-502**, which is renumbered from Section 26-36b-102 is

3863 renumbered and amended to read:

3864 ~~[26-36b-102]~~. **26B-3-502. Application.**

3865 (1) Other than for the imposition of the assessment described in this ~~[chapter]~~ part,
3866 nothing in this ~~[chapter]~~ part shall affect the nonprofit or tax exempt status of any nonprofit
3867 charitable, religious, or educational health care provider under any:

3868 (a) state law;

3869 (b) ad valorem property taxes;

3870 (c) sales or use taxes; or

3871 (d) other taxes, fees, or assessments, whether imposed or sought to be imposed, by the
3872 state or any political subdivision of the state.

3873 (2) All assessments paid under this ~~[chapter]~~ part may be included as an allowable cost
3874 of a hospital for purposes of any applicable Medicaid reimbursement formula.

3875 (3) This ~~[chapter]~~ part does not authorize a political subdivision of the state to:

3876 (a) license a hospital for revenue;

3877 (b) impose a tax or assessment upon a hospital; or

3878 (c) impose a tax or assessment measured by the income or earnings of a hospital.

3879 Section 87. Section **26B-3-503**, which is renumbered from Section 26-36b-201 is
3880 renumbered and amended to read:

3881 ~~[26-36b-201]~~. **26B-3-503. Assessment.**

3882 (1) An assessment is imposed on each private hospital:

3883 (a) beginning upon the later of CMS approval of:

3884 (i) the health coverage improvement program waiver under Section ~~[26-18-411]~~

3885 26B-3-207; and

3886 (ii) the assessment under this ~~[chapter]~~ part;

3887 (b) in the amount designated in Sections ~~[26-36b-204 and 26-36b-205]~~ 26B-3-506 and

3888 26B-3-507; and

3889 (c) in accordance with Section ~~[26-36b-202]~~ 26B-3-504.

3890 (2) Subject to Section [~~26-36b-203~~] 26B-3-505, the assessment imposed by this
3891 [~~chapter~~] part is due and payable on a quarterly basis, after payment of the outpatient upper
3892 payment limit supplemental payments under Section [~~26-36b-210~~] 26B-3-511 have been paid.

3893 (3) The first quarterly payment is not due until at least three months after the earlier of
3894 the effective dates of the coverage provided through:

- 3895 (a) the health coverage improvement program;
- 3896 (b) the enhancement waiver program; or
- 3897 (c) the Medicaid waiver expansion.

3898 Section 88. Section **26B-3-504**, which is renumbered from Section 26-36b-202 is
3899 renumbered and amended to read:

3900 [~~26-36b-202~~]. **26B-3-504. Collection of assessment -- Deposit of revenue --**
3901 **Rulemaking.**

3902 (1) The collecting agent for the assessment imposed under Section [~~26-36b-201~~]
3903 26B-3-503 is the department.

3904 (2) The department is vested with the administration and enforcement of this [~~chapter~~]
3905 part, and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative
3906 Rulemaking Act, necessary to:

- 3907 (a) collect the assessment, intergovernmental transfers, and penalties imposed under
3908 this [~~chapter~~] part;
- 3909 (b) audit records of a facility that:
 - 3910 (i) is subject to the assessment imposed by this [~~chapter~~] part; and
 - 3911 (ii) does not file a Medicare cost report; and
- 3912 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
3913 Medicare cost report.

3914 (3) The department shall:

- 3915 (a) administer the assessment in this [~~chapter~~] part separately from the assessment in
3916 [~~Chapter 36d~~] Part 7, Hospital Provider Assessment [~~Act~~]; and

3917 (b) deposit assessments collected under this [~~chapter~~] part into the Medicaid Expansion
3918 Fund created by Section [~~26-36b-208~~] 26B-1-315.

3919 Section 89. Section **26B-3-505**, which is renumbered from Section 26-36b-203 is
3920 renumbered and amended to read:

3921 ~~[26-36b-203]~~. **26B-3-505. Quarterly notice.**

3922 (1) Quarterly assessments imposed by this [~~chapter~~] part shall be paid to the division
3923 within 15 business days after the original invoice date that appears on the invoice issued by the
3924 division.

3925 (2) The department may, by rule, extend the time for paying the assessment.

3926 Section 90. Section **26B-3-506**, which is renumbered from Section 26-36b-204 is
3927 renumbered and amended to read:

3928 ~~[26-36b-204]~~. **26B-3-506. Hospital financing of health coverage**
3929 **improvement program Medicaid waiver expansion -- Hospital share.**

3930 (1) The hospital share is:

3931 (a) 45% of the state's net cost of the health coverage improvement program, including
3932 Medicaid coverage for individuals with dependent children up to the federal poverty level
3933 designated under Section [~~26-18-411~~] 26B-3-207;

3934 (b) 45% of the state's net cost of the enhancement waiver program;

3935 (c) if the waiver for the Medicaid waiver expansion is approved, \$11,900,000; and

3936 (d) 45% of the state's net cost of the upper payment limit gap.

3937 (2) (a) The hospital share is capped at no more than \$13,600,000 annually, consisting
3938 of:

3939 (i) an \$11,900,000 cap for the programs specified in Subsections (1)(a) through (c);

3940 and

3941 (ii) a \$1,700,000 cap for the program specified in Subsection (1)(d).

3942 (b) The department shall prorate the cap described in Subsection (2)(a) in any year in
3943 which the programs specified in Subsections (1)(a) and (d) are not in effect for the full fiscal

3944 year.

3945 (3) Private hospitals shall be assessed under this ~~[chapter]~~ part for:

3946 (a) 69% of the portion of the hospital share for the programs specified in Subsections
3947 (1)(a) through (c); and

3948 (b) 100% of the portion of the hospital share specified in Subsection (1)(d).

3949 (4) (a) In the report described in Subsection ~~[26-18-3.9]~~ 26B-3-113(8), the department
3950 shall calculate the state's net cost of each of the programs described in Subsections (1)(a)
3951 through (c) that are in effect for that year.

3952 (b) If the assessment collected in the previous fiscal year is above or below the hospital
3953 share for private hospitals for the previous fiscal year, the underpayment or overpayment of the
3954 assessment by the private hospitals shall be applied to the fiscal year in which the report is
3955 issued.

3956 (5) A Medicaid accountable care organization shall, on or before October 15 of each
3957 year, report to the department the following data from the prior state fiscal year for each private
3958 hospital, state teaching hospital, and non-state government hospital provider that the Medicaid
3959 accountable care organization contracts with:

3960 (a) for the traditional Medicaid population:

3961 (i) hospital inpatient payments;

3962 (ii) hospital inpatient discharges;

3963 (iii) hospital inpatient days; and

3964 (iv) hospital outpatient payments; and

3965 (b) if the Medicaid accountable care organization enrolls any individuals in the health
3966 coverage improvement program, the enhancement waiver program, or the Medicaid waiver
3967 expansion, for the population newly eligible for any of those programs:

3968 (i) hospital inpatient payments;

3969 (ii) hospital inpatient discharges;

3970 (iii) hospital inpatient days; and

3971 (iv) hospital outpatient payments.

3972 (6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
3973 Administrative Rulemaking Act, provide details surrounding specific content and format for
3974 the reporting by the Medicaid accountable care organization.

3975 Section 91. Section **26B-3-507**, which is renumbered from Section 26-36b-205 is
3976 renumbered and amended to read:

3977 ~~[26-36b-205]~~. **26B-3-507. Calculation of assessment.**

3978 (1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a
3979 quarterly basis for each private hospital in an amount calculated by the division at a uniform
3980 assessment rate for each hospital discharge, in accordance with this section.

3981 (b) A private teaching hospital with more than 425 beds and 60 residents shall pay an
3982 assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

3983 (c) The division shall calculate the uniform assessment rate described in Subsection
3984 (1)(a) by dividing the hospital share for assessed private hospitals, described in Subsections
3985 ~~[26-36b-204(1) and 26-36b-204(3)]~~ 26B-3-506(1) and (3), by the sum of:

3986 (i) the total number of discharges for assessed private hospitals that are not a private
3987 teaching hospital; and

3988 (ii) 2.5 times the number of discharges for a private teaching hospital, described in
3989 Subsection (1)(b).

3990 (d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah
3991 Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address
3992 unforeseen circumstances in the administration of the assessment under this ~~[chapter]~~ part.

3993 (e) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
3994 all assessed private hospitals.

3995 (2) Except as provided in Subsection (3), for each state fiscal year, the division shall
3996 determine a hospital's discharges as follows:

3997 (a) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year

3998 ending between July 1, 2013, and June 30, 2014; and

3999 (b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
4000 fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

4001 (3) (a) If a hospital's fiscal year Medicare cost report is not contained in the CMS
4002 Healthcare Cost Report Information System file:

4003 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
4004 applicable to the assessment year; and

4005 (ii) the division shall determine the hospital's discharges.

4006 (b) If a hospital is not certified by the Medicare program and is not required to file a
4007 Medicare cost report:

4008 (i) the hospital shall submit to the division the hospital's applicable fiscal year
4009 discharges with supporting documentation;

4010 (ii) the division shall determine the hospital's discharges from the information
4011 submitted under Subsection (3)(b)(i); and

4012 (iii) failure to submit discharge information shall result in an audit of the hospital's
4013 records and a penalty equal to 5% of the calculated assessment.

4014 (4) Except as provided in Subsection (5), if a hospital is owned by an organization that
4015 owns more than one hospital in the state:

4016 (a) the assessment for each hospital shall be separately calculated by the department;
4017 and

4018 (b) each separate hospital shall pay the assessment imposed by this ~~chapter~~ part.

4019 (5) If multiple hospitals use the same Medicaid provider number:

4020 (a) the department shall calculate the assessment in the aggregate for the hospitals
4021 using the same Medicaid provider number; and

4022 (b) the hospitals may pay the assessment in the aggregate.

4023 Section 92. Section **26B-3-508**, which is renumbered from Section 26-36b-206 is
4024 renumbered and amended to read:

4025 ~~[26-36b-206]~~. **26B-3-508. State teaching hospital and non-state government**
4026 **hospital mandatory intergovernmental transfer.**

4027 (1) The state teaching hospital and a non-state government hospital shall make an
4028 intergovernmental transfer to the Medicaid Expansion Fund created in Section ~~[26-36b-208]~~
4029 26B-1-315, in accordance with this section.

4030 (2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer
4031 beginning on the later of CMS approval of:

4032 (a) the health improvement program waiver under Section ~~[26-18-411]~~ 26B-3-207; or

4033 (b) the assessment for private hospitals in this ~~[chapter]~~ part.

4034 (3) The intergovernmental transfer is apportioned as follows:

4035 (a) the state teaching hospital is responsible for:

4036 (i) 30% of the portion of the hospital share specified in Subsections ~~[26-36b-204]~~
4037 26B-3-506(1)(a) through (c); and

4038 (ii) 0% of the hospital share specified in Subsection ~~[26-36b-204]~~ 26B-3-506(1)(d);

4039 and

4040 (b) non-state government hospitals are responsible for:

4041 (i) 1% of the portion of the hospital share specified in Subsections ~~[26-36b-204]~~
4042 26B-3-506(1)(a) through (c); and

4043 (ii) 0% of the hospital share specified in Subsection ~~[26-36b-204]~~ 26B-3-506(1)(d).

4044 (4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
4045 Administrative Rulemaking Act, designate:

4046 (a) the method of calculating the amounts designated in Subsection (3); and

4047 (b) the schedule for the intergovernmental transfers.

4048 Section 93. Section **26B-3-509**, which is renumbered from Section 26-36b-207 is
4049 renumbered and amended to read:

4050 ~~[26-36b-207]~~. **26B-3-509. Penalties and interest.**

4051 (1) A hospital that fails to pay a quarterly assessment, make the mandated

4052 intergovernmental transfer, or file a return as required under this ~~[chapter]~~ part, within the time
4053 required by this ~~[chapter]~~ part, shall pay penalties described in this section, in addition to the
4054 assessment or intergovernmental transfer.

4055 (2) If a hospital fails to timely pay the full amount of a quarterly assessment or the
4056 mandated intergovernmental transfer, the department shall add to the assessment or
4057 intergovernmental transfer:

4058 (a) a penalty equal to 5% of the quarterly amount not paid on or before the due date;
4059 and

4060 (b) on the last day of each quarter after the due date until the assessed amount and the
4061 penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

4062 (i) any unpaid quarterly assessment or intergovernmental transfer; and

4063 (ii) any unpaid penalty assessment.

4064 (3) Upon making a record of the division's actions, and upon reasonable cause shown,
4065 the division may waive, reduce, or compromise any of the penalties imposed under this
4066 ~~[chapter]~~ part.

4067 Section 94. Section **26B-3-510**, which is renumbered from Section 26-36b-209 is
4068 renumbered and amended to read:

4069 ~~[26-36b-209]~~. **26B-3-510. Hospital reimbursement.**

4070 (1) If the health coverage improvement program, the enhancement waiver program, or
4071 the Medicaid waiver expansion is implemented by contracting with a Medicaid accountable
4072 care organization, the department shall, to the extent allowed by law, include, in a contract to
4073 provide benefits under the health coverage improvement program, the enhancement waiver
4074 program, or the Medicaid waiver expansion, a requirement that the Medicaid accountable care
4075 organization reimburse hospitals in the accountable care organization's provider network at no
4076 less than the Medicaid fee-for-service rate.

4077 (2) If the health coverage improvement program, the enhancement waiver program, or
4078 the Medicaid waiver expansion is implemented by the department as a fee-for-service program,

4079 the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

4080 (3) Nothing in this section prohibits a Medicaid accountable care organization from
4081 paying a rate that exceeds the Medicaid fee-for-service rate.

4082 Section 95. Section **26B-3-511**, which is renumbered from Section 26-36b-210 is
4083 renumbered and amended to read:

4084 ~~[26-36b-210]~~. **26B-3-511. Outpatient upper payment limit supplemental**
4085 **payments.**

4086 (1) Beginning on the effective date of the assessment imposed under this ~~[chapter]~~ part,
4087 and for each subsequent fiscal year, the department shall implement an outpatient upper
4088 payment limit program for private hospitals that shall supplement the reimbursement to private
4089 hospitals in accordance with Subsection (2).

4090 (2) The division shall ensure that supplemental payment to Utah private hospitals
4091 under Subsection (1):

- 4092 (a) does not exceed the positive upper payment limit gap; and
- 4093 (b) is allocated based on the Medicaid state plan.

4094 (3) The department shall use the same outpatient data to allocate the payments under
4095 Subsection (2) and to calculate the upper payment limit gap.

4096 (4) The supplemental payments to private hospitals under Subsection (1) are payable
4097 for outpatient hospital services provided on or after the later of:

- 4098 (a) July 1, 2016;
- 4099 (b) the effective date of the Medicaid state plan amendment necessary to implement the
4100 payments under this section; or
- 4101 (c) the effective date of the coverage provided through the health coverage
4102 improvement program waiver.

4103 Section 96. Section **26B-3-512**, which is renumbered from Section 26-36b-211 is
4104 renumbered and amended to read:

4105 ~~[26-36b-211]~~. **26B-3-512. Repeal of assessment.**

4106 (1) The assessment imposed by this ~~[chapter]~~ part shall be repealed when:
4107 (a) the executive director certifies that:
4108 (i) action by Congress is in effect that disqualifies the assessment imposed by this
4109 ~~[chapter]~~ part from counting toward state Medicaid funds available to be used to determine the
4110 amount of federal financial participation;
4111 (ii) a decision, enactment, or other determination by the Legislature or by any court,
4112 officer, department, or agency of the state, or of the federal government, is in effect that:
4113 (A) disqualifies the assessment from counting toward state Medicaid funds available to
4114 be used to determine federal financial participation for Medicaid matching funds; or
4115 (B) creates for any reason a failure of the state to use the assessments for at least one of
4116 the Medicaid programs described in this ~~[chapter]~~ part; or
4117 (iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient
4118 payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1,
4119 2015; or
4120 (b) this ~~[chapter]~~ part is repealed in accordance with Section [63I-1-226](#).
4121 (2) If the assessment is repealed under Subsection (1):
4122 (a) the division may not collect any assessment or intergovernmental transfer under this
4123 ~~[chapter]~~ part;
4124 (b) the department shall disburse money in the special Medicaid Expansion Fund in
4125 accordance with the requirements in Subsection ~~[26-36b-208]~~ [26B-1-315](#)(4), to the extent
4126 federal matching is not reduced by CMS due to the repeal of the assessment;
4127 (c) any money remaining in the Medicaid Expansion Fund after the disbursement
4128 described in Subsection (2)(b) that was derived from assessments imposed by this ~~[chapter]~~
4129 part shall be refunded to the hospitals in proportion to the amount paid by each hospital for the
4130 last three fiscal years; and
4131 (d) any money remaining in the Medicaid Expansion Fund after the disbursements
4132 described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of

4133 the fiscal year that the assessment is suspended.

4134 Section 97. Section **26B-3-601**, which is renumbered from Section 26-36c-102 is
4135 renumbered and amended to read:

4136 **Part 6. Medicaid Expansion Hospital Assessment**

4137 ~~[26-36c-102]~~. **26B-3-601. Definitions.**

4138 As used in this ~~chapter~~ part:

4139 (1) "Assessment" means the Medicaid expansion hospital assessment established by
4140 this ~~chapter~~ part.

4141 (2) "CMS" means the Centers for Medicare and Medicaid Services within the United
4142 States Department of Health and Human Services.

4143 (3) "Discharges" means the number of total hospital discharges reported on:

4144 (a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost
4145 report for the applicable assessment year; or

4146 (b) a similar report adopted by the department by administrative rule, if the report
4147 under Subsection (3)(a) is no longer available.

4148 (4) "Division" means the Division of ~~Health Care Financing~~ Integrated Healthcare
4149 within the department.

4150 (5) "Hospital share" means the hospital share described in Section ~~[26-36c-203]~~
4151 26B-3-605.

4152 (6) "Medicaid accountable care organization" means a managed care organization, as
4153 defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of
4154 Section ~~[26-18-405]~~ 26B-3-202.

4155 (7) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in
4156 Section ~~[26-36b-208]~~ 26B-1-315.

4157 (8) "Medicaid waiver expansion" means the same as that term is defined in Section
4158 ~~[26-18-415]~~ 26B-3-210.

4159 (9) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of

4160 hospitals.

4161 (10) (a) "Non-state government hospital" means a hospital owned by a non-state
4162 government entity.

4163 (b) "Non-state government hospital" does not include:

4164 (i) the Utah State Hospital; or

4165 (ii) a hospital owned by the federal government, including the Veterans Administration
4166 Hospital.

4167 (11) (a) "Private hospital" means:

4168 (i) a privately owned general acute hospital operating in the state as defined in Section
4169 ~~[26-21-2]~~ [26B-2-201](#); or

4170 (ii) a privately owned specialty hospital operating in the state, including a privately
4171 owned hospital for which inpatient admissions are predominantly:

4172 (A) rehabilitation;

4173 (B) psychiatric;

4174 (C) chemical dependency; or

4175 (D) long-term acute care services.

4176 (b) "Private hospital" does not include a facility for residential treatment as defined in
4177 Section ~~[62A-2-101]~~ [26B-2-101](#).

4178 (12) "Qualified Medicaid expansion" means an expansion of the Medicaid program in
4179 accordance with Subsection ~~[26-18-3.9]~~ [26B-3-113](#)(5).

4180 (13) "State teaching hospital" means a state owned teaching hospital that is part of an
4181 institution of higher education.

4182 Section 98. Section **26B-3-602**, which is renumbered from Section 26-36c-103 is
4183 renumbered and amended to read:

4184 ~~[26-36c-103]~~. **26B-3-602. Application.**

4185 (1) Other than for the imposition of the assessment described in this ~~[chapter]~~ part,
4186 nothing in this ~~[chapter]~~ part shall affect the nonprofit or tax exempt status of any nonprofit

4187 charitable, religious, or educational health care provider under any:

4188 (a) state law;

4189 (b) ad valorem property tax requirement;

4190 (c) sales or use tax requirement; or

4191 (d) other requirements imposed by taxes, fees, or assessments, whether imposed or
4192 sought to be imposed, by the state or any political subdivision of the state.

4193 (2) A hospital paying an assessment under this ~~[chapter]~~ part may include the
4194 assessment as an allowable cost of a hospital for purposes of any applicable Medicaid
4195 reimbursement formula.

4196 (3) This ~~[chapter]~~ part does not authorize a political subdivision of the state to:

4197 (a) license a hospital for revenue;

4198 (b) impose a tax or assessment upon a hospital; or

4199 (c) impose a tax or assessment measured by the income or earnings of a hospital.

4200 Section 99. Section **26B-3-603**, which is renumbered from Section 26-36c-201 is
4201 renumbered and amended to read:

4202 ~~[26-36c-201]~~. **26B-3-603. Assessment.**

4203 (1) An assessment is imposed on each private hospital:

4204 (a) beginning upon the later of:

4205 (i) April 1, 2019; and

4206 (ii) CMS approval of the assessment under this ~~[chapter]~~ part;

4207 (b) in the amount designated in Sections ~~[26-36c-204 and 26-36c-205]~~ 26B-3-606 and
4208 26B-3-607; and

4209 (c) in accordance with Section ~~[26-36c-202]~~ 26B-3-604.

4210 (2) The assessment imposed by this ~~[chapter]~~ part is due and payable in accordance
4211 with Subsection ~~[26-36c-202]~~ 26B-3-604(4).

4212 Section 100. Section **26B-3-604**, which is renumbered from Section 26-36c-202 is
4213 renumbered and amended to read:

4214 ~~[26-36c-202]~~. 26B-3-604. **Collection of assessment -- Deposit of revenue --**
4215 **Rulemaking.**

4216 (1) The department shall act as the collecting agent for the assessment imposed under
4217 Section ~~[26-36c-201]~~ 26B-3-603.

4218 (2) The department shall administer and enforce the provisions of this ~~[chapter]~~ part,
4219 and may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative
4220 Rulemaking Act, necessary to:

4221 (a) collect the assessment, intergovernmental transfers, and penalties imposed under
4222 this ~~[chapter]~~ part;

4223 (b) audit records of a facility that:

4224 (i) is subject to the assessment imposed under this ~~[chapter]~~ part; and

4225 (ii) does not file a Medicare cost report; and

4226 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
4227 Medicare cost report.

4228 (3) The department shall:

4229 (a) administer the assessment in this part separately from the assessments in [~~Chapter~~
4230 ~~36d]~~ Part 7, Hospital Provider Assessment [~~Act, and Chapter 36b]~~, and Part 5, Inpatient
4231 Hospital Assessment [~~Act~~]; and

4232 (b) deposit assessments collected under this ~~[chapter]~~ part into the Medicaid Expansion
4233 Fund.

4234 (4) (a) Hospitals shall pay the quarterly assessments imposed by this ~~[chapter]~~ part to
4235 the division within 15 business days after the original invoice date that appears on the invoice
4236 issued by the division.

4237 (b) The department may make rules creating requirements to allow the time for paying
4238 the assessment to be extended.

4239 Section 101. Section **26B-3-605**, which is renumbered from Section 26-36c-203 is
4240 renumbered and amended to read:

4241 ~~[26-36c-203]~~. 26B-3-605. Hospital share.

4242 (1) The hospital share is:

4243 (a) for the period from April 1, 2019, through June 30, 2020, \$15,000,000; and

4244 (b) beginning July 1, 2020, 100% of the state's net cost of the qualified Medicaid

4245 expansion, after deducting appropriate offsets and savings expected as a result of implementing
4246 the qualified Medicaid expansion, including:

4247 (i) savings from:

4248 (A) the Primary Care Network program;

4249 (B) the health coverage improvement program, as defined in Section ~~[26-18-411]~~

4250 26B-3-207;

4251 (C) the state portion of inpatient prison medical coverage;

4252 (D) behavioral health coverage; and

4253 (E) county contributions to the non-federal share of Medicaid expenditures; and

4254 (ii) any funds appropriated to the Medicaid Expansion Fund.

4255 (2) (a) Beginning July 1, 2020, the hospital share is capped at no more than
4256 \$15,000,000 annually.

4257 (b) Beginning July 1, 2020, the division shall prorate the cap specified in Subsection

4258 (2)(a) in any year in which the qualified Medicaid expansion is not in effect for the full fiscal
4259 year.

4260 Section 102. Section **26B-3-606**, which is renumbered from Section 26-36c-204 is
4261 renumbered and amended to read:

4262 ~~[26-36c-204]~~. 26B-3-606. Hospital financing.

4263 (1) Private hospitals shall be assessed under this ~~[chapter]~~ part for the portion of the
4264 hospital share described in Section ~~[26-36c-209]~~ 26B-3-611.

4265 (2) In the report described in Subsection ~~[26-18-3-9]~~ 26B-3-113(8), the department
4266 shall calculate the state's net cost of the qualified Medicaid expansion.

4267 (3) If the assessment collected in the previous fiscal year is above or below the hospital

4268 share for private hospitals for the previous fiscal year, the division shall apply the
4269 underpayment or overpayment of the assessment by the private hospitals to the fiscal year in
4270 which the report is issued.

4271 Section 103. Section **26B-3-607**, which is renumbered from Section 26-36c-205 is
4272 renumbered and amended to read:

4273 ~~[26-36c-205]~~. **26B-3-607. Calculation of assessment.**

4274 (1) (a) Except as provided in Subsection (1)(b), each private hospital shall pay an
4275 annual assessment due on the last day of each quarter in an amount calculated by the division at
4276 a uniform assessment rate for each hospital discharge, in accordance with this section.

4277 (b) A private teaching hospital with more than 425 beds and more than 60 residents
4278 shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

4279 (c) The division shall calculate the uniform assessment rate described in Subsection
4280 (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection
4281 ~~[26-36c-204]~~ 26B-3-606(1), by the sum of:

4282 (i) the total number of discharges for assessed private hospitals that are not a private
4283 teaching hospital; and

4284 (ii) 2.5 times the number of discharges for a private teaching hospital, described in
4285 Subsection (1)(b).

4286 (d) The division may make rules in accordance with Title 63G, Chapter 3, Utah
4287 Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address
4288 unforeseen circumstances in the administration of the assessment under this ~~[chapter]~~ part.

4289 (e) The division shall apply any quarterly changes to the uniform assessment rate
4290 uniformly to all assessed private hospitals.

4291 (2) Except as provided in Subsection (3), for each state fiscal year, the division shall
4292 determine a hospital's discharges as follows:

4293 (a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year
4294 ending between July 1, 2015, and June 30, 2016; and

4295 (b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
4296 fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

4297 (3) (a) If a hospital's fiscal year Medicare cost report is not contained in the Centers for
4298 Medicare and Medicaid Services' Healthcare Cost Report Information System file:

4299 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
4300 applicable to the assessment year; and

4301 (ii) the division shall determine the hospital's discharges.

4302 (b) If a hospital is not certified by the Medicare program and is not required to file a
4303 Medicare cost report:

4304 (i) the hospital shall submit to the division the hospital's applicable fiscal year
4305 discharges with supporting documentation;

4306 (ii) the division shall determine the hospital's discharges from the information
4307 submitted under Subsection (3)(b)(i); and

4308 (iii) if the hospital fails to submit discharge information, the division shall audit the
4309 hospital's records and may impose a penalty equal to 5% of the calculated assessment.

4310 (4) Except as provided in Subsection (5), if a hospital is owned by an organization that
4311 owns more than one hospital in the state:

4312 (a) the division shall calculate the assessment for each hospital separately; and

4313 (b) each separate hospital shall pay the assessment imposed by this ~~chapter~~ part.

4314 (5) If multiple hospitals use the same Medicaid provider number:

4315 (a) the department shall calculate the assessment in the aggregate for the hospitals
4316 using the same Medicaid provider number; and

4317 (b) the hospitals may pay the assessment in the aggregate.

4318 Section 104. Section **26B-3-608**, which is renumbered from Section 26-36c-206 is
4319 renumbered and amended to read:

4320 ~~[26-36c-206]~~. **26B-3-608. State teaching hospital and non-state government**
4321 **hospital mandatory intergovernmental transfer.**

4322 (1) A state teaching hospital and a non-state government hospital shall make an
4323 intergovernmental transfer to the Medicaid Expansion Fund, in accordance with this section.

4324 (2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer
4325 beginning on the later of:

4326 (a) April 1, 2019; or

4327 (b) CMS approval of the assessment for private hospitals in this ~~[chapter]~~ part.

4328 (3) The intergovernmental transfer is apportioned between the non-state government
4329 hospitals as follows:

4330 (a) the state teaching hospital shall pay for the portion of the hospital share described in
4331 Section ~~[26-36c-209]~~ 26B-3-611; and

4332 (b) non-state government hospitals shall pay for the portion of the hospital share
4333 described in Section ~~[26-36c-209]~~ 26B-3-611.

4334 (4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah
4335 Administrative Rulemaking Act, designate:

4336 (a) the method of calculating the amounts designated in Subsection (3); and

4337 (b) the schedule for the intergovernmental transfers.

4338 Section 105. Section **26B-3-609**, which is renumbered from Section 26-36c-207 is
4339 renumbered and amended to read:

4340 ~~[26-36c-207]~~. **26B-3-609. Penalties.**

4341 (1) A hospital that fails to pay a quarterly assessment, make the mandated
4342 intergovernmental transfer, or file a return as required under this ~~[chapter]~~ part, within the time
4343 required by this ~~[chapter]~~ part, shall pay penalties described in this section, in addition to the
4344 assessment or intergovernmental transfer.

4345 (2) If a hospital fails to timely pay the full amount of a quarterly assessment or the
4346 mandated intergovernmental transfer, the department shall add to the assessment or
4347 intergovernmental transfer:

4348 (a) a penalty equal to 5% of the quarterly amount not paid on or before the due date;

4349 and

4350 (b) on the last day of each quarter after the due date until the assessed amount and the
4351 penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:

4352 (i) any unpaid quarterly assessment or intergovernmental transfer; and

4353 (ii) any unpaid penalty assessment.

4354 (3) Upon making a record of the division's actions, and upon reasonable cause shown,
4355 the division may waive or reduce any of the penalties imposed under this [chapter] part.

4356 Section 106. Section **26B-3-610**, which is renumbered from Section 26-36c-208 is
4357 renumbered and amended to read:

4358 ~~[26-36c-208]~~. **26B-3-610. Hospital reimbursement.**

4359 (1) If the qualified Medicaid expansion is implemented by contracting with a Medicaid
4360 accountable care organization, the department shall, to the extent allowed by law, include in a
4361 contract to provide benefits under the qualified Medicaid expansion a requirement that the
4362 accountable care organization reimburse hospitals in the accountable care organization's
4363 provider network at no less than the Medicaid fee-for-service rate.

4364 (2) If the qualified Medicaid expansion is implemented by the department as a
4365 fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid
4366 fee-for-service rate.

4367 (3) Nothing in this section prohibits the department or a Medicaid accountable care
4368 organization from paying a rate that exceeds the Medicaid fee-for-service rate.

4369 Section 107. Section **26B-3-611**, which is renumbered from Section 26-36c-209 is
4370 renumbered and amended to read:

4371 ~~[26-36c-209]~~. **26B-3-611. Hospital financing of the hospital share.**

4372 (1) For the first two full fiscal years that the assessment is in effect, the department
4373 shall:

4374 (a) assess private hospitals under this [chapter] part for 69% of the hospital share;

4375 (b) require the state teaching hospital to make an intergovernmental transfer under this

4376 [chapter] part for 30% of the hospital share; and

4377 (c) require non-state government hospitals to make an intergovernmental transfer under
4378 this [chapter] part for 1% of the hospital share.

4379 (2) (a) At the beginning of the third full fiscal year that the assessment is in effect, and
4380 at the beginning of each subsequent fiscal year, the department may set a different percentage
4381 share for private hospitals, the state teaching hospital, and non-state government hospitals by
4382 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, with
4383 input from private hospitals and private teaching hospitals.

4384 (b) If the department does not set a different percentage share under Subsection (2)(a),
4385 the percentage shares in Subsection (1) shall apply.

4386 Section 108. Section **26B-3-612**, which is renumbered from Section 26-36c-210 is
4387 renumbered and amended to read:

4388 ~~[26-36c-210]~~. **26B-3-612. Suspension of assessment.**

4389 (1) The department shall suspend the assessment imposed by this [chapter] part when
4390 the executive director certifies that:

4391 (a) action by Congress is in effect that disqualifies the assessment imposed by this
4392 [chapter] part from counting toward state Medicaid funds available to be used to determine the
4393 amount of federal financial participation;

4394 (b) a decision, enactment, or other determination by the Legislature or by any court,
4395 officer, department, or agency of the state, or of the federal government, is in effect that:

4396 (i) disqualifies the assessment from counting toward state Medicaid funds available to
4397 be used to determine federal financial participation for Medicaid matching funds; or

4398 (ii) creates for any reason a failure of the state to use the assessments for at least one of
4399 the Medicaid programs described in this [chapter] part; or

4400 (c) a change is in effect that reduces the aggregate hospital inpatient and outpatient
4401 payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1,
4402 2015.

- 4403 (2) If the assessment is suspended under Subsection (1):
4404 (a) the division may not collect any assessment or intergovernmental transfer under this
4405 ~~[chapter]~~ part;
4406 (b) the division shall disburse money in the Medicaid Expansion Fund that was derived
4407 from assessments imposed by this ~~[chapter]~~ part in accordance with the requirements in
4408 Subsection ~~[26-36b-208]~~ 26B-1-315(4), to the extent federal matching is not reduced by CMS
4409 due to the repeal of the assessment; and
4410 (c) the division shall refund any money remaining in the Medicaid Expansion Fund
4411 after the disbursement described in Subsection (2)(b) that was derived from assessments
4412 imposed by this ~~[chapter]~~ part to the hospitals in proportion to the amount paid by each hospital
4413 for the last three fiscal years.

4414 Section 109. Section **26B-3-701**, which is renumbered from Section 26-36d-103 is
4415 renumbered and amended to read:

4416 **Part 7. Hospital Provider Assessment**

4417 ~~[26-36d-103]~~. **26B-3-701. Definitions.**

4418 As used in this ~~[chapter]~~ part:

- 4419 (1) "Accountable care organization" means a managed care organization, as defined in
4420 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section
4421 ~~[26-18-405]~~ 26B-3-202.
4422 (2) "Assessment" means the Medicaid hospital provider assessment established by this
4423 ~~[chapter]~~ part.
4424 (3) "Discharges" means the number of total hospital discharges reported on Worksheet
4425 S-3 Part I, column 15, lines 12, 14, and 14.01 of the 2552-96 Medicare Cost Report or on
4426 Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare Cost Report for
4427 the applicable assessment year.
4428 (4) "Division" means the Division of ~~[Health Care Financing]~~ Integrated Healthcare of
4429 the department.

- 4430 (5) "Hospital":
- 4431 (a) means a privately owned:
- 4432 (i) general acute hospital operating in the state as defined in Section [~~26-21-2~~]
- 4433 [26B-2-201](#); and
- 4434 (ii) specialty hospital operating in the state, which shall include a privately owned
- 4435 hospital whose inpatient admissions are predominantly:
- 4436 (A) rehabilitation;
- 4437 (B) psychiatric;
- 4438 (C) chemical dependency; or
- 4439 (D) long-term acute care services; and
- 4440 (b) does not include:
- 4441 (i) a human services program, as defined in Section [~~62A-2-101~~] [26B-2-101](#);
- 4442 (ii) a hospital owned by the federal government, including the Veterans Administration
- 4443 Hospital; or
- 4444 (iii) a hospital that is owned by the state government, a state agency, or a political
- 4445 subdivision of the state, including:
- 4446 (A) a state-owned teaching hospital; and
- 4447 (B) the Utah State Hospital.
- 4448 (6) "Medicare Cost Report" means CMS-2552-96 or CMS-2552-10, the cost report for
- 4449 electronic filing of hospitals.
- 4450 (7) "State plan amendment" means a change or update to the state Medicaid plan.
- 4451 Section 110. Section **26B-3-702**, which is renumbered from Section 26-36d-102 is
- 4452 renumbered and amended to read:
- 4453 ~~[26-36d-102]~~. **26B-3-702. Legislative findings.**
- 4454 (1) The Legislature finds that there is an important state purpose to improve the access
- 4455 of Medicaid patients to quality care in Utah hospitals because of continuous decreases in state
- 4456 revenues and increases in enrollment under the Utah Medicaid program.

4457 (2) The Legislature finds that in order to improve this access to those persons described
4458 in Subsection (1):

4459 (a) the rates paid to Utah hospitals shall be adequate to encourage and support
4460 improved access; and

4461 (b) adequate funding shall be provided to increase the rates paid to Utah hospitals
4462 providing services pursuant to the Utah Medicaid program.

4463 Section 111. Section **26B-3-703**, which is renumbered from Section 26-36d-201 is
4464 renumbered and amended to read:

4465 ~~[26-36d-201]~~. **26B-3-703. Application of part.**

4466 (1) Other than for the imposition of the assessment described in this ~~[chapter]~~ part,
4467 nothing in this ~~[chapter]~~ part shall affect the nonprofit or tax exempt status of any nonprofit
4468 charitable, religious, or educational health care provider under:

4469 (a) Section 501(c), as amended, of the Internal Revenue Code;

4470 (b) other applicable federal law;

4471 (c) any state law;

4472 (d) any ad valorem property taxes;

4473 (e) any sales or use taxes; or

4474 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by
4475 the state or any political subdivision, county, municipality, district, authority, or any agency or
4476 department thereof.

4477 (2) All assessments paid under this ~~[chapter]~~ part may be included as an allowable cost
4478 of a hospital for purposes of any applicable Medicaid reimbursement formula.

4479 (3) This ~~[chapter]~~ part does not authorize a political subdivision of the state to:

4480 (a) license a hospital for revenue;

4481 (b) impose a tax or assessment upon hospitals; or

4482 (c) impose a tax or assessment measured by the income or earnings of a hospital.

4483 Section 112. Section **26B-3-704**, which is renumbered from Section 26-36d-202 is

4484 renumbered and amended to read:

4485 ~~[26-36d-202]~~. **26B-3-704. Assessment, collection, and payment of hospital**
4486 **provider assessment.**

4487 (1) A uniform, broad based, assessment is imposed on each hospital as defined in
4488 Subsection ~~[26-36d-103]~~ 26B-3-701(5)(a):

- 4489 (a) in the amount designated in Section ~~[26-36d-203]~~ 26B-3-705; and
- 4490 (b) in accordance with Section ~~[26-36d-204]~~ 26B-3-706.

4491 (2) (a) The assessment imposed by this ~~[chapter]~~ part is due and payable on a quarterly
4492 basis in accordance with Section ~~[26-36d-204]~~ 26B-3-706.

4493 (b) The collecting agent for this assessment is the department which is vested with the
4494 administration and enforcement of this ~~[chapter]~~ part, including the right to adopt
4495 administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
4496 Act, necessary to:

- 4497 (i) implement and enforce the provisions of this act; and
- 4498 (ii) audit records of a facility:
 - 4499 (A) that is subject to the assessment imposed by this ~~[chapter]~~ part; and
 - 4500 (B) does not file a Medicare Cost Report.

4501 (c) The department shall forward proceeds from the assessment imposed by this
4502 ~~[chapter]~~ part to the state treasurer for deposit in the expendable special revenue fund as
4503 specified in Section ~~[26-36d-207]~~ 26B-1-316.

4504 (3) The department may, by rule, extend the time for paying the assessment.

4505 Section 113. Section **26B-3-705**, which is renumbered from Section 26-36d-203 is
4506 renumbered and amended to read:

4507 ~~[26-36d-203]~~. **26B-3-705. Calculation of assessment.**

4508 (1) (a) An annual assessment is payable on a quarterly basis for each hospital in an
4509 amount calculated at a uniform assessment rate for each hospital discharge, in accordance with
4510 this section.

4511 (b) The uniform assessment rate shall be determined using the total number of hospital
4512 discharges for assessed hospitals divided into the total non-federal portion in an amount
4513 consistent with Section [~~26-36d-205~~] 26B-3-707 that is needed to support capitated rates for
4514 accountable care organizations for purposes of hospital services provided to Medicaid
4515 enrollees.

4516 (c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
4517 all assessed hospitals.

4518 (d) The annual uniform assessment rate may not generate more than:

4519 (i) \$1,000,000 to offset Medicaid mandatory expenditures; and

4520 (ii) the non-federal share to seed amounts needed to support capitated rates for
4521 accountable care organizations as provided for in Subsection (1)(b).

4522 (2) (a) For each state fiscal year, discharges shall be determined using the data from
4523 each hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid
4524 Services' Healthcare Cost Report Information System file. The hospital's discharge data will be
4525 derived as follows:

4526 (i) for state fiscal year 2013, the hospital's cost report data for the hospital's fiscal year
4527 ending between July 1, 2009, and June 30, 2010;

4528 (ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year
4529 ending between July 1, 2010, and June 30, 2011;

4530 (iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year
4531 ending between July 1, 2011, and June 30, 2012;

4532 (iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year
4533 ending between July 1, 2012, and June 30, 2013; and

4534 (v) for each subsequent state fiscal year, the hospital's cost report data for the hospital's
4535 fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.

4536 (b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for
4537 Medicare and Medicaid Services' Healthcare Cost Report Information System file:

4538 (i) the hospital shall submit to the division a copy of the hospital's Medicare Cost
4539 Report applicable to the assessment year; and

4540 (ii) the division shall determine the hospital's discharges.

4541 (c) If a hospital is not certified by the Medicare program and is not required to file a
4542 Medicare Cost Report:

4543 (i) the hospital shall submit to the division its applicable fiscal year discharges with
4544 supporting documentation;

4545 (ii) the division shall determine the hospital's discharges from the information
4546 submitted under Subsection (2)(c)(i); and

4547 (iii) the failure to submit discharge information shall result in an audit of the hospital's
4548 records and a penalty equal to 5% of the calculated assessment.

4549 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
4550 owns more than one hospital in the state:

4551 (a) the assessment for each hospital shall be separately calculated by the department;
4552 and

4553 (b) each separate hospital shall pay the assessment imposed by this ~~[chapter]~~ part.

4554 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the
4555 same Medicaid provider number:

4556 (a) the department shall calculate the assessment in the aggregate for the hospitals
4557 using the same Medicaid provider number; and

4558 (b) the hospitals may pay the assessment in the aggregate.

4559 Section 114. Section **26B-3-706**, which is renumbered from Section 26-36d-204 is
4560 renumbered and amended to read:

4561 ~~[26-36d-204]~~. **26B-3-706. Quarterly notice -- Collection.**

4562 Quarterly assessments imposed by this ~~[chapter]~~ part shall be paid to the division within
4563 15 business days after the original invoice date that appears on the invoice issued by the
4564 division.

4565 Section 115. Section **26B-3-707**, which is renumbered from Section 26-36d-205 is
4566 renumbered and amended to read:

4567 ~~[26-36d-205]~~. **26B-3-707**. **Medicaid hospital adjustment under accountable**
4568 **care organization rates.**

4569 To preserve and improve access to hospital services, the division shall, for accountable
4570 care organization rates effective on or after April 1, 2013, incorporate into the accountable care
4571 organization rate structure calculation consistent with the certified actuarial rate range:

4572 (1) \$154,000,000 to be allocated toward the hospital inpatient directed payments for
4573 the Medicaid eligibility categories covered in Utah before January 1, 2019; and

4574 (2) an amount equal to the difference between payments made to hospitals by
4575 accountable care organizations for the Medicaid eligibility categories covered in Utah before
4576 January 1, 2019, based on submitted encounter data and the maximum amount that could be
4577 paid for those services using Medicare payment principles to be used for directed payments to
4578 hospitals for outpatient services.

4579 Section 116. Section **26B-3-708**, which is renumbered from Section 26-36d-206 is
4580 renumbered and amended to read:

4581 ~~[26-36d-206]~~. **26B-3-708**. **Penalties and interest.**

4582 (1) A facility that fails to pay any assessment or file a return as required under this
4583 ~~[chapter] part~~, within the time required by this ~~[chapter] part~~, shall pay, in addition to the
4584 assessment, penalties and interest established by the department.

4585 (2) (a) Consistent with Subsection (2)(b), the department shall adopt rules in
4586 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish
4587 reasonable penalties and interest for the violations described in Subsection (1).

4588 (b) If a hospital fails to timely pay the full amount of a quarterly assessment, the
4589 department shall add to the assessment:

4590 (i) a penalty equal to 5% of the quarterly amount not paid on or before the due date;

4591 and

4592 (ii) on the last day of each quarter after the due date until the assessed amount and the
4593 penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:

4594 (A) any unpaid quarterly assessment; and

4595 (B) any unpaid penalty assessment.

4596 (c) Upon making a record of its actions, and upon reasonable cause shown, the division
4597 may waive, reduce, or compromise any of the penalties imposed under this part.

4598 Section 117. Section **26B-3-709**, which is renumbered from Section 26-36d-208 is
4599 renumbered and amended to read:

4600 ~~[26-36d-208]~~. **26B-3-709. Repeal of assessment.**

4601 (1) The repeal of the assessment imposed by this ~~[chapter]~~ part shall occur upon the
4602 certification by the executive director of the department that the sooner of the following has
4603 occurred:

4604 (a) the effective date of any action by Congress that would disqualify the assessment
4605 imposed by this ~~[chapter]~~ part from counting toward state Medicaid funds available to be used
4606 to determine the federal financial participation;

4607 (b) the effective date of any decision, enactment, or other determination by the
4608 Legislature or by any court, officer, department, or agency of the state, or of the federal
4609 government that has the effect of:

4610 (i) disqualifying the assessment from counting towards state Medicaid funds available
4611 to be used to determine federal financial participation for Medicaid matching funds; or

4612 (ii) creating for any reason a failure of the state to use the assessments for the Medicaid
4613 program as described in this ~~[chapter]~~ part;

4614 (c) the effective date of:

4615 (i) an appropriation for any state fiscal year from the General Fund for hospital
4616 payments under the state Medicaid program that is less than the amount appropriated for state
4617 fiscal year 2012;

4618 (ii) the annual revenues of the state General Fund budget return to the level that was

4619 appropriated for fiscal year 2008;
4620 (iii) a division change in rules that reduces any of the following below July 1, 2011,
4621 payments:
4622 (A) aggregate hospital inpatient payments;
4623 (B) adjustment payment rates; or
4624 (C) any cost settlement protocol; or
4625 (iv) a division change in rules that reduces the aggregate outpatient payments below
4626 July 1, 2011, payments; and
4627 (d) the sunset of this ~~[chapter]~~ part in accordance with Section [631-1-226](#).

4628 (2) If the assessment is repealed under Subsection (1), money in the fund that was
4629 derived from assessments imposed by this ~~[chapter]~~ part, before the determination made under
4630 Subsection (1), shall be disbursed under Section ~~[26-36d-205]~~ [26B-3-707](#) to the extent federal
4631 matching is not reduced due to the impermissibility of the assessments. Any funds remaining in
4632 the special revenue fund shall be refunded to the hospitals in proportion to the amount paid by
4633 each hospital.

4634 Section 118. Section **26B-3-801**, which is renumbered from Section 26-37a-102 is
4635 renumbered and amended to read:

4636 **Part 8. Ambulance Service Provider Assessment**

4637 ~~[26-37a-102]~~. **26B-3-801. Definitions.**

4638 As used in this ~~[chapter]~~ part:

4639 (1) "Ambulance service provider" means:

4640 (a) an ambulance provider as defined in Section ~~[26-8a-102]~~ [26B-4-101](#); or

4641 (b) a non-911 service provider as defined in Section ~~[26-8a-102]~~ [26B-4-101](#).

4642 (2) "Assessment" means the Medicaid ambulance service provider assessment
4643 established by this ~~[chapter]~~ part.

4644 (3) "Division" means the Division of ~~[Health Care Financing]~~ Integrated Healthcare
4645 within the department.

4646 (4) "Non-federal portion" means the non-federal share the division needs to seed
4647 amounts that will support fee-for-service ambulance service provider rates, as described in
4648 Section ~~[26-37a-105]~~ [26B-3-804](#).

4649 (5) "Total transports" means the number of total ambulance transports applicable to a
4650 given fiscal year, as determined under Subsection ~~[26-37a-104]~~ [26B-3-803](#)(5).

4651 Section 119. Section **26B-3-802**, which is renumbered from Section 26-37a-103 is
4652 renumbered and amended to read:

4653 ~~[26-37a-103]~~. **26B-3-802. Assessment, collection, and payment of**
4654 **ambulance service provider assessment.**

4655 (1) An ambulance service provider shall pay an assessment to the division:

4656 (a) in the amount designated in Section ~~[26-37a-104]~~ [26B-3-803](#);

4657 (b) in accordance with this ~~[chapter]~~ part;

4658 (c) quarterly, on a day determined by the division by rule made under Subsection

4659 (2)(b); and

4660 (d) no more than 15 business days after the day on which the division issues the
4661 ambulance service provider notice of the assessment.

4662 (2) The division shall:

4663 (a) collect the assessment described in Subsection (1);

4664 (b) determine, by rule made in accordance with Title 63G, Chapter 3, Utah

4665 Administrative Rulemaking Act, standards and procedures for implementing and enforcing the

4666 provisions of this ~~[chapter]~~ part; and

4667 (c) transfer assessment proceeds to the state treasurer for deposit into the Ambulance

4668 Service Provider Assessment Expendable Revenue Fund created in Section ~~[26-37a-107]~~

4669 [26B-1-317](#).

4670 Section 120. Section **26B-3-803**, which is renumbered from Section 26-37a-104 is
4671 renumbered and amended to read:

4672 ~~[26-37a-104]~~. **26B-3-803. Calculation of assessment.**

4673 (1) The division shall calculate a uniform assessment per transport as described in this
4674 section.

4675 (2) The assessment due from a given ambulance service provider equals the
4676 non-federal portion divided by total transports, multiplied by the number of transports for the
4677 ambulance service provider.

4678 (3) The division shall apply any quarterly changes to the assessment rate, calculated as
4679 described in Subsection (2), uniformly to all assessed ambulance service providers.

4680 (4) The assessment may not generate more than the total of:

4681 (a) an annual amount of \$20,000 to offset Medicaid administration expenses; and

4682 (b) the non-federal portion.

4683 (5) (a) For each state fiscal year, the division shall calculate total transports using data
4684 from the Emergency Medical System as follows:

4685 (i) for state fiscal year 2016, the division shall use ambulance service provider
4686 transports during the 2014 calendar year; and

4687 (ii) for a fiscal year after 2016, the division shall use ambulance service provider
4688 transports during the calendar year ending 18 months before the end of the fiscal year.

4689 (b) If an ambulance service provider fails to submit transport information to the
4690 Emergency Medical System, the division may audit the ambulance service provider to
4691 determine the ambulance service provider's transports for a given fiscal year.

4692 Section 121. Section **26B-3-804**, which is renumbered from Section 26-37a-105 is
4693 renumbered and amended to read:

4694 ~~[26-37a-105]~~. **26B-3-804. Medicaid ambulance service provider adjustment**
4695 **under fee-for-service rates.**

4696 The division shall, if the assessment imposed by this [chapter] part is approved by the
4697 Centers for Medicare and Medicaid Services, for fee-for-service rates effective on or after July
4698 1, 2015, reimburse an ambulance service provider in an amount up to the Emergency Medical
4699 Services Ambulance Rates adopted annually by the department.

4700 Section 122. Section **26B-3-805**, which is renumbered from Section 26-37a-106 is
4701 renumbered and amended to read:

4702 ~~[26-37a-106]~~. **26B-3-805. Penalties.**

4703 The division shall require an ambulance service provider that fails to pay an assessment
4704 due under this ~~[chapter]~~ part to pay the division, in addition to the assessment, a penalty
4705 determined by the division by rule made in accordance with Title 63G, Chapter 3, Utah
4706 Administrative Rulemaking Act.

4707 Section 123. Section **26B-3-806**, which is renumbered from Section 26-37a-108 is
4708 renumbered and amended to read:

4709 ~~[26-37a-108]~~. **26B-3-806. Repeal of assessment.**

4710 (1) This ~~[chapter]~~ part is repealed when, as certified by the executive director of the
4711 department, any of the following occurs:

4712 (a) an action by Congress that disqualifies the assessment imposed by this ~~[chapter]~~
4713 part from state Medicaid funds available to be used to determine the federal financial
4714 participation takes legal effect; or

4715 (b) an action, decision, enactment, or other determination by the Legislature or by any
4716 court, officer, department, or agency of the state or federal government takes effect that:

4717 (i) disqualifies the assessment from counting toward state Medicaid funds available to
4718 be used to determine federal financial participation for Medicaid matching funds; or

4719 (ii) creates for any reason a failure of the state to use the assessments for the Medicaid
4720 program as described in this ~~[chapter]~~ part.

4721 (2) If this ~~[chapter]~~ part is repealed under Subsection (1):

4722 (a) money in the Ambulance Service Provider Assessment Expendable Revenue Fund
4723 that was derived from assessments imposed by this ~~[chapter]~~ part, deposited before the
4724 determination made under Subsection (1), shall be disbursed under Section ~~[26-37a-107]~~
4725 26B-1-317 to the extent federal matching is not reduced due to the impermissibility of the
4726 assessments; and

4727 (b) any funds remaining in the special revenue fund shall be refunded to each
4728 ambulance service provider in proportion to the amount paid by the ambulance service
4729 provider.

4730 Section 124. Section **26B-3-901**, which is renumbered from Section 26-40-102 is
4731 renumbered and amended to read:

4732 **Part 9. Utah Children's Health Insurance Program**

4733 ~~[26-40-102].~~ **26B-3-901. Definitions.**

4734 As used in this ~~[chapter]~~ part:

4735 (1) "Child" means ~~[a person who is under 19 years of age]~~ an individual who is
4736 younger than 19 years old.

4737 (2) "Eligible child" means a child who qualifies for enrollment in the program as
4738 provided in Section ~~[26-40-105]~~ 26B-3-903.

4739 (3) "Member" means a child enrolled in the program.

4740 (4) "Plan" means the department's plan submitted to the United States Department of
4741 Health and Human Services pursuant to 42 U.S.C. Sec. 1397ff.

4742 (5) "Program" means the Utah Children's Health Insurance Program created by this
4743 ~~[chapter]~~ part.

4744 Section 125. Section **26B-3-902**, which is renumbered from Section 26-40-103 is
4745 renumbered and amended to read:

4746 ~~[26-40-103].~~ **26B-3-902. Creation and administration of the Utah**
4747 **Children's Health Insurance Program.**

4748 (1) There is created the Utah Children's Health Insurance Program to be administered
4749 by the department in accordance with the provisions of:

4750 (a) this ~~[chapter]~~ part; and

4751 (b) the State Children's Health Insurance Program, 42 U.S.C. Sec. 1397aa et seq.

4752 (2) The department shall:

4753 (a) prepare and submit the state's children's health insurance plan before May 1, 1998,

4754 and any amendments to the [~~federal~~] United States Department of Health and Human Services
4755 in accordance with 42 U.S.C. Sec. 1397ff; and

4756 (b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
4757 Rulemaking Act, regarding:

4758 (i) eligibility requirements consistent with Section [~~26-18-3~~] 26B-3-108;

4759 (ii) program benefits;

4760 (iii) the level of coverage for each program benefit;

4761 (iv) cost-sharing requirements for members, which may not:

4762 (A) exceed the guidelines set forth in 42 U.S.C. Sec. 1397ee; or

4763 (B) impose deductible, copayment, or coinsurance requirements on a member for
4764 well-child, well-baby, and immunizations;

4765 (v) the administration of the program; and

4766 (vi) a requirement that:

4767 (A) members in the program shall participate in the electronic exchange of clinical
4768 health records established in accordance with Section [~~26-1-37~~] 26B-8-411 unless the member
4769 opts out of participation;

4770 (B) prior to enrollment in the electronic exchange of clinical health records the member
4771 shall receive notice of the enrollment in the electronic exchange of clinical health records and
4772 the right to opt out of participation at any time; and

4773 (C) beginning July 1, 2012, when the program sends enrollment or renewal information
4774 to the member and when the member logs onto the program's website, the member shall
4775 receive notice of the right to opt out of the electronic exchange of clinical health records.

4776 Section 126. Section **26B-3-903**, which is renumbered from Section 26-40-105 is
4777 renumbered and amended to read:

4778 [~~26-40-105~~]. **26B-3-903. Eligibility.**

4779 (1) A child is eligible to enroll in the program if the child:

4780 (a) is a bona fide Utah resident;

- 4781 (b) is a citizen or legal resident of the United States;
- 4782 (c) is under 19 years of age;
- 4783 (d) does not have access to or coverage under other health insurance, including any
- 4784 coverage available through a parent or legal guardian's employer;
- 4785 (e) is ineligible for Medicaid benefits;
- 4786 (f) resides in a household whose gross family income, as defined by rule, is at or below
- 4787 200% of the federal poverty level; and
- 4788 (g) is not an inmate of a public institution or a patient in an institution for mental
- 4789 diseases.

4790 (2) A child who qualifies for enrollment in the program under Subsection (1) may not

4791 be denied enrollment due to a diagnosis or pre-existing condition.

4792 (3) (a) The department shall determine eligibility and send notification of the eligibility

4793 decision within 30 days after receiving the application for coverage.

4794 (b) If the department cannot reach a decision because the applicant fails to take a

4795 required action, or because there is an administrative or other emergency beyond the

4796 department's control, the department shall:

- 4797 (i) document the reason for the delay in the applicant's case record; and
- 4798 (ii) inform the applicant of the status of the application and time frame for completion.

4799 (4) The department may not close enrollment in the program for a child who is eligible

4800 to enroll in the program under the provisions of Subsection (1).

4801 (5) The program shall:

- 4802 (a) apply for grants to make technology system improvements necessary to implement
- 4803 a simplified enrollment and renewal process in accordance with Subsection (5)(b); and
- 4804 (b) if funding is available, implement a simplified enrollment and renewal process.

4805 Section 127. Section **26B-3-904**, which is renumbered from Section 26-40-106 is

4806 renumbered and amended to read:

4807 ~~[26-40-106].~~ **26B-3-904. Program benefits.**

4808 (1) Except as provided in Subsection (3), medical and dental program benefits shall be
4809 benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, as follows:

4810 (a) medical program benefits, including behavioral health care benefits, shall be
4811 benchmarked effective July 1, 2019, and on July 1 every third year thereafter, to:

4812 (i) be substantially equal to a health benefit plan with the largest insured commercial
4813 enrollment offered by a health maintenance organization in the state; and

4814 (ii) comply with the Mental Health Parity and Addiction Equity Act, Pub. L. No.
4815 110-343; and

4816 (b) dental program benefits shall be benchmarked effective July 1, 2019, and on July 1
4817 every third year thereafter in accordance with the Children's Health Insurance Program
4818 Reauthorization Act of 2009, to be substantially equal to a dental benefit plan that has the
4819 largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the
4820 state, except that the utilization review mechanism for orthodontia shall be based on medical
4821 necessity.

4822 (2) On or before July 1 of each year, the department shall publish the benchmark for
4823 dental program benefits established under Subsection (1)(b).

4824 (3) The program benefits:

4825 (a) for enrollees who are at or below 100% of the federal poverty level are exempt
4826 from the benchmark requirements of Subsections (1) and (2); and

4827 (b) shall include treatment for autism spectrum disorder as defined in Section
4828 [31A-22-642](#), which:

4829 (i) shall include coverage for applied behavioral analysis; and

4830 (ii) if the benchmark described in Subsection (1)(a) does not include the coverage
4831 described in this Subsection (3)(b), the department shall exclude from the benchmark described
4832 in Subsection (1)(a) for any purpose other than providing benefits under the program.

4833 Section 128. Section **26B-3-905**, which is renumbered from Section 26-40-107 is
4834 renumbered and amended to read:

4835 ~~[26-40-107]~~. **26B-3-905. Limitation of benefits.**

4836 Abortion is not a covered benefit, except as provided in 42 U.S.C. Sec. 1397ee.

4837 Section 129. Section **26B-3-906**, which is renumbered from Section 26-40-108 is

4838 renumbered and amended to read:

4839 ~~[26-40-108]~~. **26B-3-906. Funding.**

4840 (1) The program shall be funded by federal matching funds received under, together
4841 with state matching funds required by, 42 U.S.C. Sec. 1397ee.

4842 (2) Program expenditures in the following categories may not exceed 10% in the
4843 aggregate of all federal payments pursuant to 42 U.S.C. Sec. 1397ee:

4844 (a) other forms of child health assistance for children with gross family incomes below
4845 200% of the federal poverty level;

4846 (b) other health services initiatives to improve low-income children's health;

4847 (c) outreach program expenditures; and

4848 (d) administrative costs.

4849 Section 130. Section **26B-3-907**, which is renumbered from Section 26-40-109 is
4850 renumbered and amended to read:

4851 ~~[26-40-109]~~. **26B-3-907. Evaluation.**

4852 The department shall develop performance measures and annually evaluate the
4853 program's performance.

4854 Section 131. Section **26B-3-908**, which is renumbered from Section 26-40-110 is
4855 renumbered and amended to read:

4856 ~~[26-40-110]~~. **26B-3-908. Managed care -- Contracting for services.**

4857 (1) Program benefits provided to a member under the program, as described in Section
4858 ~~[26-40-106]~~ 26B-3-904, shall be delivered by a managed care organization if the department
4859 determines that adequate services are available where the member lives or resides.

4860 (2) The department may contract with a managed care organization to provide program
4861 benefits. The department shall evaluate a potential contract with a managed care organization

4862 based on:

4863 (a) the managed care organization's:

4864 (i) ability to manage medical expenses, including mental health costs;

4865 (ii) proven ability to handle accident and health insurance;

4866 (iii) efficiency of claim paying procedures;

4867 (iv) proven ability for managed care and quality assurance;

4868 (v) provider contracting and discounts;

4869 (vi) pharmacy benefit management;

4870 (vii) estimated total charges for administering the pool;

4871 (viii) ability to administer the pool in a cost-efficient manner;

4872 (ix) ability to provide adequate providers and services in the state; and

4873 (x) ability to meet quality measures for emergency room use and access to primary care

4874 established by the department under Subsection [~~26-18-408~~] [26B-3-204](#)(4); and

4875 (b) other factors established by the department.

4876 (3) The department may enter into separate managed care organization contracts to
4877 provide dental benefits required by Section [~~26-40-106~~] [26B-3-904](#).

4878 (4) The department's contract with a managed care organization for the program's
4879 benefits shall include risk sharing provisions in which the plan shall accept at least 75% of the
4880 risk for any difference between the department's premium payments per member and actual
4881 medical expenditures.

4882 (5) (a) The department may contract with the Group Insurance Division within the
4883 Utah State Retirement Office to provide services under Subsection (1) if no managed care
4884 organization is willing to contract with the department or the department determines no
4885 managed care organization meets the criteria established under Subsection (2).

4886 (b) In accordance with Section [49-20-201](#), a contract awarded under Subsection (5)(a)
4887 is not subject to the risk sharing required by Subsection (4).

4888 Section 132. Section **26B-3-909**, which is renumbered from Section 26-40-115 is

4889 renumbered and amended to read:

4890 ~~[26-40-115]~~. 26B-3-909. **State contractor -- Employee and dependent**
4891 **health benefit plan coverage.**

4892 (1) For purposes of Sections [17B-2a-818.5](#), [19-1-206](#), [63A-5b-607](#), [63C-9-403](#),
4893 [72-6-107.5](#), and [79-2-404](#), "qualified health coverage" means, at the time the contract is entered
4894 into or renewed:

4895 (a) a health benefit plan and employer contribution level with a combined actuarial
4896 value at least actuarially equivalent to the combined actuarial value of:

4897 (i) the benchmark plan determined by the program under Subsection ~~[26-40-106]~~
4898 [26B-3-904](#)(1)(a); and

4899 (ii) a contribution level at which the employer pays at least 50% of the premium or
4900 contribution amounts for the employee and the dependents of the employee who reside or work
4901 in the state; or

4902 (b) a federally qualified high deductible health plan that, at a minimum:

4903 (i) has a deductible that is:

4904 (A) the lowest deductible permitted for a federally qualified high deductible health
4905 plan; or

4906 (B) a deductible that is higher than the lowest deductible permitted for a federally
4907 qualified high deductible health plan, but includes an employer contribution to a health savings
4908 account in a dollar amount at least equal to the dollar amount difference between the lowest
4909 deductible permitted for a federally qualified high deductible plan and the deductible for the
4910 employer offered federally qualified high deductible plan;

4911 (ii) has an out-of-pocket maximum that does not exceed three times the amount of the
4912 annual deductible; and

4913 (iii) provides that the employer pays 60% of the premium or contribution amounts for
4914 the employee and the dependents of the employee who work or reside in the state.

4915 (2) The department shall:

- 4916 (a) on or before July 1, 2016:
- 4917 (i) determine the commercial equivalent of the benchmark plan described in Subsection
- 4918 (1)(a); and
- 4919 (ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i)
- 4920 on the department's website, noting the date posted; and
- 4921 (b) update the posted commercially equivalent benchmark plan annually and at the
- 4922 time of any change in the benchmark.

4923 Section 133. Section **26B-3-1001**, which is renumbered from Section 26-19-102 is
 4924 renumbered and amended to read:

Part 10. Medical Benefits Recovery

~~[26-19-102].~~ **26B-3-1001. Definitions.**

As used in this ~~[chapter]~~ part:

- 4928 (1) "Annuity" shall have the same meaning as provided in Section [31A-1-301](#).
- 4929 (2) "Care facility" means:
 - 4930 (a) a nursing facility;
 - 4931 (b) an intermediate care facility for an individual with an intellectual disability; or
 - 4932 (c) any other medical institution.
- 4933 (3) "Claim" means:
 - 4934 (a) a request or demand for payment; or
 - 4935 (b) a cause of action for money or damages arising under any law.
- 4936 (4) "Employee welfare benefit plan" means a medical insurance plan developed by an
 4937 employer under 29 U.S.C. ~~[Section]~~ Sec. 1001, et seq., the Employee Retirement Income
 4938 Security Act of 1974 as amended.
- 4939 (5) "Health insurance entity" means:
 - 4940 (a) an insurer;
 - 4941 (b) a person who administers, manages, provides, offers, sells, carries, or underwrites
 - 4942 health insurance, as defined in Section [31A-1-301](#);

- 4943 (c) a self-insured plan;
- 4944 (d) a group health plan, as defined in Subsection 607(1) of the federal Employee
- 4945 Retirement Income Security Act of 1974;
- 4946 (e) a service benefit plan;
- 4947 (f) a managed care organization;
- 4948 (g) a pharmacy benefit manager;
- 4949 (h) an employee welfare benefit plan; or
- 4950 (i) a person who is, by statute, contract, or agreement, legally responsible for payment
- 4951 of a claim for a health care item or service.

4952 (6) "Inpatient" means an individual who is a patient and a resident of a care facility.

4953 (7) "Insurer" includes:

4954 (a) a group health plan as defined in Subsection 607(1) of the federal Employee

4955 Retirement Income Security Act of 1974;

4956 (b) a health maintenance organization; and

4957 (c) any entity offering a health service benefit plan.

4958 (8) "Medical assistance" means:

4959 (a) all funds expended for the benefit of a recipient under ~~[Title 26, Chapter 18;~~

4960 ~~Medical Assistance Act, or under] this chapter or Titles XVIII and XIX, federal Social Security~~

4961 ~~Act; and~~

4962 (b) any other services provided for the benefit of a recipient by a prepaid health care

4963 delivery system under contract with the department.

4964 (9) "Office of Recovery Services" means the Office of Recovery Services within the

4965 ~~[Department of Human Services]~~ department.

4966 (10) "Provider" means a person or entity who provides services to a recipient.

4967 (11) "Recipient" means:

4968 (a) an individual who has applied for or received medical assistance from the state;

4969 (b) the guardian, conservator, or other personal representative of an individual under

4970 Subsection (11)(a) if the individual is a minor or an incapacitated person; or
4971 (c) the estate and survivors of an individual under Subsection (11)(a), if the individual
4972 is deceased.

4973 (12) "Recovery estate" means, regarding a deceased recipient:

4974 (a) all real and personal property or other assets included within a decedent's estate as
4975 defined in Section 75-1-201;

4976 (b) the decedent's augmented estate as defined in Section 75-2-203; and

4977 (c) that part of other real or personal property in which the decedent had a legal interest
4978 at the time of death including assets conveyed to a survivor, heir, or assign of the decedent
4979 through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other
4980 arrangement.

4981 (13) "State plan" means the state Medicaid program as enacted in accordance with Title
4982 XIX, federal Social Security Act.

4983 (14) "TEFRA lien" means a lien, authorized under the Tax Equity and Fiscal
4984 Responsibility Act of 1982, against the real property of an individual prior to the individual's
4985 death, as described in 42 U.S.C. Sec. 1396p.

4986 (15) "Third party" includes:

4987 (a) an individual, institution, corporation, public or private agency, trust, estate,
4988 insurance carrier, employee welfare benefit plan, health maintenance organization, health
4989 service organization, preferred provider organization, governmental program such as Medicare,
4990 CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the
4991 medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by
4992 department rule; and

4993 (b) a spouse or a parent who:

4994 (i) may be obligated to pay all or part of the medical costs of a recipient under law or
4995 by court or administrative order; or

4996 (ii) has been ordered to maintain health, dental, or accident and health insurance to

4997 cover medical expenses of a spouse or dependent child by court or administrative order.

4998 (16) "Trust" shall have the same meaning as provided in Section [75-1-201](#).

4999 Section 134. Section **26B-3-1002**, which is renumbered from Section 26-19-103 is
5000 renumbered and amended to read:

5001 ~~[26-19-103]~~. **26B-3-1002**. **Program established by department --**
5002 **Promulgation of rules.**

5003 (1) The department shall establish and maintain a program for the recoupment of
5004 medical assistance.

5005 (2) The department may promulgate rules to implement the purposes of this [~~chapter~~]
5006 part.

5007 Section 135. Section **26B-3-1003**, which is renumbered from Section 26-19-201 is
5008 renumbered and amended to read:

5009 ~~[26-19-201]~~. **26B-3-1003**. **Assignment of rights to benefits.**

5010 (1) (a) Except as provided in Subsection [~~26-19-401~~] [26B-3-1009](#)(1), to the extent that
5011 medical assistance is actually provided to a recipient, all benefits for medical services or
5012 payments from a third-party otherwise payable to or on behalf of a recipient are assigned by
5013 operation of law to the department if the department provides, or becomes obligated to provide,
5014 medical assistance, regardless of who made application for the benefits on behalf of the
5015 recipient.

5016 (b) The assignment:

5017 (i) authorizes the department to submit its claim to the third-party and authorizes
5018 payment of benefits directly to the department; and

5019 (ii) is effective for all medical assistance.

5020 (2) The department may recover the assigned benefits or payments in accordance with
5021 Section [~~26-19-401~~] [26B-3-1009](#) and as otherwise provided by law.

5022 (3) (a) The assignment of benefits includes medical support and third-party payments
5023 ordered, decreed, or adjudged by any court of this state or any other state or territory of the

5024 United States.

5025 (b) The assignment is not in lieu of, and does not supersede or alter any other court
5026 order, decree, or judgment.

5027 (4) When an assignment takes effect, the recipient is entitled to receive medical
5028 assistance, and the benefits paid to the department are a reimbursement to the department.

5029 Section 136. Section **26B-3-1004**, which is renumbered from Section 26-19-301 is
5030 renumbered and amended to read:

5031 ~~[26-19-301]~~. **26B-3-1004. Health insurance entity -- Duties related to state**
5032 **claims for Medicaid payment or recovery.**

5033 As a condition of doing business in the state, a health insurance entity shall:

5034 (1) with respect to an individual who is eligible for, or is provided, medical assistance
5035 under the state plan, upon the request of the ~~[Department of Health]~~ department, provide
5036 information to determine:

5037 (a) during what period the individual, or the spouse or dependent of the individual, may
5038 be or may have been, covered by the health insurance entity; and

5039 (b) the nature of the coverage that is or was provided by the health insurance entity
5040 described in Subsection (1)(a), including the name, address, and identifying number of the
5041 plan;

5042 (2) accept the state's right of recovery and the assignment to the state of any right of an
5043 individual to payment from a party for an item or service for which payment has been made
5044 under the state plan;

5045 (3) respond to any inquiry by the ~~[Department of Health]~~ department regarding a claim
5046 for payment for any health care item or service that is submitted no later than three years after
5047 the day on which the health care item or service is provided; and

5048 (4) not deny a claim submitted by the ~~[Department of Health]~~ department solely on the
5049 basis of the date of submission of the claim, the type or format of the claim form, or failure to
5050 present proper documentation at the point-of-sale that is the basis for the claim, if:

5051 (a) the claim is submitted no later than three years after the day on which the item or
5052 service is furnished; and

5053 (b) any action by the [~~Department of Health~~] department to enforce the rights of the
5054 state with respect to the claim is commenced no later than six years after the day on which the
5055 claim is submitted.

5056 Section 137. Section **26B-3-1005**, which is renumbered from Section 26-19-302 is
5057 renumbered and amended to read:

5058 ~~[26-19-302]~~. **26B-3-1005. Insurance policies not to deny or reduce benefits**
5059 **of individuals eligible for state medical assistance -- Exemptions.**

5060 (1) A policy of accident or sickness insurance may not contain any provision denying
5061 or reducing benefits because services are rendered to an insured or dependent who is eligible
5062 for or receiving medical assistance from the state.

5063 (2) An association, corporation, or organization may not deliver, issue for delivery, or
5064 renew any subscriber's contract which contains any provisions denying or reducing benefits
5065 because services are rendered to a subscriber or dependent who is eligible for or receiving
5066 medical assistance from the state.

5067 (3) An association, corporation, business, or organization authorized to do business in
5068 this state and which provides or pays for any health care benefits may not deny or reduce
5069 benefits because services are rendered to a beneficiary who is eligible for or receiving medical
5070 assistance from the state.

5071 (4) Notwithstanding Subsection (1), (2), or (3), the Utah State Public Employees'
5072 Health Program, administered by the Utah State Retirement Board, is not required to reimburse
5073 any agency of state government for custodial care which the agency provides, through its staff
5074 or facilities, to members of the Utah State Public Employees' Health Program.

5075 Section 138. Section **26B-3-1006**, which is renumbered from Section 26-19-303 is
5076 renumbered and amended to read:

5077 ~~[26-19-303]~~. **26B-3-1006. Availability of insurance policy.**

5078 If the third party does not pay the department's claim or lien within 30 days from the
5079 date the claim or lien is received, the third party shall:

- 5080 (1) provide a written explanation if the claim is denied;
5081 (2) specifically describe and request any additional information from the department
5082 that is necessary to process the claim; and
5083 (3) provide the department or its agent a copy of any relevant or applicable insurance
5084 or benefit policy.

5085 Section 139. Section **26B-3-1007**, which is renumbered from Section 26-19-304 is
5086 renumbered and amended to read:

5087 ~~[26-19-304].~~ **26B-3-1007. Employee benefit plans.**

5088 As allowed pursuant to 29 U.S.C. [~~Section~~] Sec. 1144, an employee benefit plan may
5089 not include any provision that has the effect of limiting or excluding coverage or payment for
5090 any health care for an individual who would otherwise be covered or entitled to benefits or
5091 services under the terms of the employee benefit plan based on the fact that the individual is
5092 eligible for or is provided services under the state plan.

5093 Section 140. Section **26B-3-1008**, which is renumbered from Section 26-19-305 is
5094 renumbered and amended to read:

5095 ~~[26-19-305].~~ **26B-3-1008. Statute of limitations -- Survival of right of**
5096 **action -- Insurance policy not to limit time allowed for recovery.**

5097 (1) (a) Subject to Subsection (6), action commenced by the department under this
5098 [~~chapter~~] part against a health insurance entity shall be commenced within:

5099 (i) subject to Subsection (7), six years after the day on which the department submits
5100 the claim for recovery or payment for the health care item or service upon which the action is
5101 based; or

5102 (ii) six months after the date of the last payment for medical assistance, whichever is
5103 later.

5104 (b) An action against any other third party, the recipient, or anyone to whom the

5105 proceeds are payable shall be commenced within:

5106 (i) four years after the date of the injury or onset of the illness; or

5107 (ii) six months after the date of the last payment for medical assistance, whichever is

5108 later.

5109 (2) The death of the recipient does not abate any right of action established by this

5110 ~~[chapter]~~ part.

5111 (3) (a) No insurance policy issued or renewed after June 1, 1981, may contain any

5112 provision that limits the time in which the department may submit its claim to recover medical

5113 assistance benefits to a period of less than 24 months from the date the provider furnishes

5114 services or goods to the recipient.

5115 (b) No insurance policy issued or renewed after April 30, 2007, may contain any

5116 provision that limits the time in which the department may submit its claim to recover medical

5117 assistance benefits to a period of less than that described in Subsection (1)(a).

5118 (4) The provisions of this section do not apply to Section ~~[26-19-405 or Part 5, TEFRA~~

5119 ~~Liens]~~ 26B-3-1013 or Sections 26B-3-1015 through 26B-3-1023.

5120 (5) The provisions of this section ~~[supercede]~~ supersede any other sections regarding

5121 the time limit in which an action shall be commenced, including Section 75-7-509.

5122 (6) (a) Subsection (1)(a) extends the statute of limitations on a cause of action

5123 described in Subsection (1)(a) that was not time-barred on or before April 30, 2007.

5124 (b) Subsection (1)(a) does not revive a cause of action that was time-barred on or

5125 before April 30, 2007.

5126 (7) An action described in Subsection (1)(a) may not be commenced if the claim for

5127 recovery or payment described in Subsection (1)(a)(i) is submitted later than three years after

5128 the day on which the health care item or service upon which the claim is based was provided.

5129 Section 141. Section **26B-3-1009**, which is renumbered from Section 26-19-401 is

5130 renumbered and amended to read:

5131 ~~[26-19-401]~~. **26B-3-1009**. **Recovery of medical assistance from third party**

5132 -- Lien -- Notice -- Action -- Compromise or waiver -- Recipient's right to action
 5133 protected.

5134 (1) (a) Except as provided in Subsection (1)(c), if the department provides or becomes
 5135 obligated to provide medical assistance to a recipient that a third-party is obligated to pay for,
 5136 the department may recover the medical assistance directly from the third-party.

5137 (b) (i) A claim under Subsection (1)(a) or Section [~~26-19-201~~] [26B-3-1003](#) to recover
 5138 medical assistance provided to a recipient is a lien against any proceeds payable to or on behalf
 5139 of the recipient by the third-party.

5140 (ii) The lien described in Subsection (1)(b)(i) has priority over all other claims to the
 5141 proceeds, except claims for attorney fees and costs authorized under Subsection [~~26-19-403~~]
 5142 [26B-3-1011](#)(2)(c)(ii).

5143 (c) (i) The department may not recover medical assistance under Subsection (1)(a) if:

5144 (A) the third-party is obligated to pay the recipient for an injury to the recipient's child
 5145 that occurred while the child was in the physical custody of the child's foster parent;

5146 (B) the child's injury is a physical or mental impairment that requires ongoing medical
 5147 attention, or limits activities of daily living, for at least one year;

5148 (C) the third-party's payment to the recipient is placed in a trust, annuity, financial
 5149 account, or other financial instrument for the benefit of the child; and

5150 (D) the recipient makes reasonable efforts to mitigate any other medical assistance
 5151 costs for the recipient to the state.

5152 (ii) The department is responsible for any repayment to the federal government related
 5153 to the medical assistance the department is prohibited from recovering under Subsection
 5154 (1)(c)(i).

5155 (2) (a) The department shall mail or deliver written notice of the department's claim or
 5156 lien to the third-party at the third-party's principal place of business or last-known address.

5157 (b) The notice shall include:

5158 (i) the recipient's name;

- 5159 (ii) the approximate date of illness or injury;
- 5160 (iii) a general description of the type of illness or injury; and
- 5161 (iv) if applicable, the general location where the injury is alleged to have occurred.
- 5162 (3) The department may commence an action on the department's claim or lien in the
- 5163 department's name, but the claim or lien is not enforceable as to a third-party unless:
- 5164 (a) the third-party receives written notice of the department's claim or lien before the
- 5165 third-party settles with the recipient; or
- 5166 (b) the department has evidence that the third party had knowledge that the department
- 5167 provided or was obligated to provide medical assistance.
- 5168 (4) The department may:
- 5169 (a) waive a claim or lien against a third party in whole or in part; or
- 5170 (b) compromise, settle, or release a claim or lien.
- 5171 (5) An action commenced under this section does not bar an action by a recipient or a
- 5172 dependent of a recipient for loss or damage not included in the department's action.
- 5173 (6) Except as provided in Subsection (1)(c), the department's claim or lien on proceeds
- 5174 under this section is not affected by the transfer of the proceeds to a trust, annuity, financial
- 5175 account, or other financial instrument.
- 5176 Section 142. Section **26B-3-1010**, which is renumbered from Section 26-19-402 is
- 5177 renumbered and amended to read:
- 5178 ~~[26-19-402]~~. **26B-3-1010. Action by department -- Notice to recipient.**
- 5179 (1) (a) Within 30 days after commencing an action under Subsection [~~26-19-401~~]
- 5180 [26B-3-1009](#)(3), the department shall give the recipient, the recipient's guardian, personal
- 5181 representative, trustee, estate, or survivor, whichever is appropriate, written notice of the action
- 5182 by:
- 5183 (i) personal service or certified mail to the last known address of the person receiving
- 5184 the notice; or
- 5185 (ii) if no last-known address is available, by publishing a notice:

5186 (A) once a week for three successive weeks in a newspaper of general circulation in the
5187 county where the recipient resides; and

5188 (B) in accordance with Section 45-1-101 for three weeks.

5189 (b) Proof of service shall be filed in the action.

5190 (c) The recipient may intervene in the department's action at any time before trial.

5191 (2) The notice required by Subsection (1) shall name the court in which the action is
5192 commenced and advise the recipient of:

5193 (a) the right to intervene in the proceeding;

5194 (b) the right to obtain a private attorney; and

5195 (c) the department's right to recover medical assistance directly from the third party.

5196 Section 143. Section **26B-3-1011**, which is renumbered from Section 26-19-403 is
5197 renumbered and amended to read:

5198 ~~[26-19-403]~~. **26B-3-1011. Notice of claim by recipient -- Department**
5199 **response -- Conditions for proceeding -- Collection agreements.**

5200 (1) (a) A recipient may not file a claim, commence an action, or settle, compromise,
5201 release, or waive a claim against a third party for recovery of medical costs for an injury,
5202 disease, or disability for which the department has provided or has become obligated to provide
5203 medical assistance, without the department's written consent as provided in Subsection (2)(b)
5204 or (4).

5205 (b) For purposes of Subsection (1)(a), consent may be obtained if:

5206 (i) a recipient who files a claim, or commences an action against a third party notifies
5207 the department in accordance with Subsection (1)(d) within 10 days of the recipient making the
5208 claim or commencing an action; or

5209 (ii) an attorney, who has been retained by the recipient to file a claim, or commence an
5210 action against a third party, notifies the department in accordance with Subsection (1)(d) of the
5211 recipient's claim:

5212 (A) within 30 days after being retained by the recipient for that purpose; or

5213 (B) within 30 days from the date the attorney either knew or should have known that
5214 the recipient received medical assistance from the department.

5215 (c) Service of the notice of claim to the department shall be made by certified mail,
5216 personal service, or by e-mail in accordance with Rule 5 of the Utah Rules of Civil Procedure,
5217 to the director of the Office of Recovery Services.

5218 (d) The notice of claim shall include the following information:

5219 (i) the name of the recipient;

5220 (ii) the recipient's Social Security number;

5221 (iii) the recipient's date of birth;

5222 (iv) the name of the recipient's attorney if applicable;

5223 (v) the name or names of individuals or entities against whom the recipient is making
5224 the claim, if known;

5225 (vi) the name of the third party's insurance carrier, if known;

5226 (vii) the date of the incident giving rise to the claim; and

5227 (viii) a short statement identifying the nature of the recipient's claim.

5228 (2) (a) Within 30 days of receipt of the notice of the claim required in Subsection (1),
5229 the department shall acknowledge receipt of the notice of the claim to the recipient or the
5230 recipient's attorney and shall notify the recipient or the recipient's attorney in writing of the
5231 following:

5232 (i) if the department has a claim or lien pursuant to Section [~~26-19-401~~] [26B-3-1009](#) or
5233 has become obligated to provide medical assistance; and

5234 (ii) whether the department is denying or granting written consent in accordance with
5235 Subsection (1)(a).

5236 (b) The department shall provide the recipient's attorney the opportunity to enter into a
5237 collection agreement with the department, with the recipient's consent, unless:

5238 (i) the department, prior to the receipt of the notice of the recipient's claim pursuant to
5239 Subsection (1), filed a written claim with the third party, the third party agreed to make

5240 payment to the department before the date the department received notice of the recipient's
5241 claim, and the agreement is documented in the department's record; or

5242 (ii) there has been a failure by the recipient's attorney to comply with any provision of
5243 this section by:

5244 (A) failing to comply with the notice provisions of this section;

5245 (B) failing or refusing to enter into a collection agreement;

5246 (C) failing to comply with the terms of a collection agreement with the department; or

5247 (D) failing to disburse funds owed to the state in accordance with this section.

5248 (c) (i) The collection agreement shall be:

5249 (A) consistent with this section and the attorney's obligation to represent the recipient
5250 and represent the state's claim; and

5251 (B) state the terms under which the interests of the department may be represented in
5252 an action commenced by the recipient.

5253 (ii) If the recipient's attorney enters into a written collection agreement with the
5254 department, or includes the department's claim in the recipient's claim or action pursuant to
5255 Subsection (4), the department shall pay attorney fees at the rate of 33.3% of the department's
5256 total recovery and shall pay a proportionate share of the litigation expenses directly related to
5257 the action.

5258 (d) The department is not required to enter into a collection agreement with the
5259 recipient's attorney for collection of personal injury protection under Subsection
5260 [31A-22-302\(2\)](#).

5261 (3) (a) If the department receives notice pursuant to Subsection (1), and notifies the
5262 recipient and the recipient's attorney that the department will not enter into a collection
5263 agreement with the recipient's attorney, the recipient may proceed with the recipient's claim or
5264 action against the third party if the recipient excludes from the claim:

5265 (i) any medical expenses paid by the department; or

5266 (ii) any medical costs for which the department is obligated to provide medical

5267 assistance.

5268 (b) When a recipient proceeds with a claim under Subsection (3)(a), the recipient shall
5269 provide written notice to the third party of the exclusion of the department's claim for expenses
5270 under Subsection (3)(a)(i) or (ii).

5271 (4) If the department receives notice pursuant to Subsection (1), and does not respond
5272 within 30 days to the recipient or the recipient's attorney, the recipient or the recipient's
5273 attorney:

5274 (a) may proceed with the recipient's claim or action against the third party;

5275 (b) may include the state's claim in the recipient's claim or action; and

5276 (c) may not negotiate, compromise, settle, or waive the department's claim without the
5277 department's consent.

5278 Section 144. Section **26B-3-1012**, which is renumbered from Section 26-19-404 is
5279 renumbered and amended to read:

5280 ~~[26-19-404]~~. **26B-3-1012**. **Department's right to intervene -- Department's**
5281 **interests protected -- Remitting funds -- Disbursements -- Liability and penalty for**
5282 **noncompliance.**

5283 (1) The department has an unconditional right to intervene in an action commenced by
5284 a recipient against a third party for the purpose of recovering medical costs for which the
5285 department has provided or has become obligated to provide medical assistance.

5286 (2) (a) If the recipient proceeds without complying with the provisions of Section
5287 ~~[26-19-403]~~ 26B-3-1011, the department is not bound by any decision, judgment, agreement,
5288 settlement, or compromise rendered or made on the claim or in the action.

5289 (b) The department:

5290 (i) may recover in full from the recipient, or any party to which the proceeds were
5291 made payable, all medical assistance that the department has provided; and

5292 (ii) retains its right to commence an independent action against the third party, subject
5293 to Subsection ~~[26-19-404]~~ 26B-3-1009(3).

5294 (3) Any amounts assigned to and recoverable by the department pursuant to Sections
5295 [~~26-19-201 and 26-19-401~~] 26B-3-1003 and 26B-3-1009 collected directly by the recipient
5296 shall be remitted to the Bureau of Medical Collections within the Office of Recovery Services
5297 no later than five business days after receipt.

5298 (4) (a) Any amounts assigned to and recoverable by the department pursuant to
5299 Sections [~~26-19-201 and 26-19-401~~] 26B-3-1003 and 26B-3-1009 collected directly by the
5300 recipient's attorney shall be remitted to the Bureau of Medical Collections within the Office of
5301 Recovery Services no later than 30 days after the funds are placed in the attorney's trust
5302 account.

5303 (b) The date by which the funds shall be remitted to the department may be modified
5304 based on agreement between the department and the recipient's attorney.

5305 (c) The department's consent to another date for remittance may not be unreasonably
5306 withheld.

5307 (d) If the funds are received by the recipient's attorney, no disbursements shall be made
5308 to the recipient or the recipient's attorney until the department's claim has been paid.

5309 (5) A recipient or recipient's attorney who knowingly and intentionally fails to comply
5310 with this section is liable to the department for:

5311 (a) the amount of the department's claim or lien pursuant to Subsection (1);

5312 (b) a penalty equal to 10% of the amount of the department's claim; and

5313 (c) attorney fees and litigation expenses related to recovering the department's claim.

5314 Section 145. Section **26B-3-1013**, which is renumbered from Section 26-19-405 is
5315 renumbered and amended to read:

5316 [~~26-19-405~~]. **26B-3-1013. Estate and trust recovery.**

5317 (1) (a) Except as provided in Subsection (1)(b), upon a recipient's death, the
5318 department may recover from the recipient's recovery estate and any trust, in which the
5319 recipient is the grantor and a beneficiary, medical assistance correctly provided for the benefit
5320 of the recipient when the recipient was 55 years [~~of age~~] old or older.

- 5321 (b) The department may not make an adjustment or a recovery under Subsection (1)(a):
5322 (i) while the deceased recipient's spouse is still living; or
5323 (ii) if the deceased recipient has a surviving child who is:
5324 (A) under [age] 21 years old; or
5325 (B) blind or disabled, as defined in the state plan.
- 5326 (2) (a) The amount of medical assistance correctly provided for the benefit of a
5327 recipient and recoverable under this section is a lien against the deceased recipient's recovery
5328 estate or any trust when the recipient is the grantor and a beneficiary.
- 5329 (b) The lien holds the same priority as reasonable and necessary medical expenses of
5330 the last illness as provided in Section [75-3-805](#).
- 5331 (3) (a) For a lien described in Subsection (2), the department shall provide notice in
5332 accordance with Section [38-12-102](#).
- 5333 (b) Before final distribution, the department shall perfect the lien as follows:
5334 (i) for an estate, by presenting the lien to the estate's personal representative in
5335 accordance with Section [75-3-804](#); and
5336 (ii) for a trust, by presenting the lien to the trustee in accordance with Section
5337 [75-7-510](#).
- 5338 (c) The department may file an amended lien before the entry of the final order to close
5339 the estate or trust.
- 5340 (4) Claims against a deceased recipient's inter vivos trust shall be presented in
5341 accordance with Sections [75-7-509](#) and [75-7-510](#).
- 5342 (5) Any trust provision that denies recovery for medical assistance is void at the time of
5343 its making.
- 5344 (6) Nothing in this section affects the right of the department to recover Medicaid
5345 assistance before a recipient's death under Section [~~26-19-201~~ or Section [26-19-406](#)]
5346 [26B-3-1003](#) or [26B-3-1014](#).
- 5347 (7) A lien imposed under this section is of indefinite duration.

5348 Section 146. Section **26B-3-1014**, which is renumbered from Section 26-19-406 is
5349 renumbered and amended to read:

5350 ~~[26-19-406]~~. **26B-3-1014**. **Recovery from recipient of incorrectly provided**
5351 **medical assistance.**

5352 The department may:

5353 (1) recover medical assistance incorrectly provided, whether due to administrative or
5354 factual error or fraud, from the recipient or the recipient's recovery estate; and

5355 (2) pursuant to a judgment, impose a lien against real property of the recipient.

5356 Section 147. Section **26B-3-1015**, which is renumbered from Section 26-19-501 is
5357 renumbered and amended to read:

5358 ~~[26-19-501]~~. **26B-3-1015**. **TEFRA liens authorized -- Grounds for TEFRA**
5359 **liens -- Exemptions.**

5360 (1) Except as provided in Subsections (2) and (3), the department may impose a
5361 TEFRA lien on the real property of an individual for the amount of medical assistance provided
5362 for, or to, the individual while the individual is an inpatient in a care facility, if:

5363 (a) the individual is an inpatient in a care facility;

5364 (b) the individual is required, as a condition of receiving services under the state plan,
5365 to spend for costs of medical care all but a minimal amount of the individual's income required
5366 for personal needs; and

5367 (c) the department determines that the individual cannot reasonably be expected to:

5368 (i) be discharged from the care facility; and

5369 (ii) return to the individual's home.

5370 (2) The department may not impose a lien on the home of an individual described in
5371 Subsection (1), if any of the following individuals are lawfully residing in the home:

5372 (a) the spouse of the individual;

5373 (b) a child of the individual, if the child is:

5374 (i) under 21 years ~~[of age]~~ old; or

5375 (ii) blind or permanently and totally disabled, as defined in Title 42 U.S.C. Sec.
5376 1382c(a)(3)(F); or

5377 (c) a sibling of the individual, if the sibling:

5378 (i) has an equity interest in the home; and

5379 (ii) resided in the home for at least one year immediately preceding the day on which
5380 the individual was admitted to the care facility.

5381 (3) The department may not impose a TEFRA lien on the real property of an
5382 individual, unless:

5383 (a) the individual has been an inpatient in a care facility for the 180-day period
5384 immediately preceding the day on which the lien is imposed;

5385 (b) the department serves:

5386 (i) a preliminary notice of intent to impose a TEFRA lien relating to the real property,
5387 in accordance with Section [~~26-19-503~~] [26B-3-1017](#); and

5388 (ii) a final notice of intent to impose a TEFRA lien relating to the real property, in
5389 accordance with Section [~~26-19-504~~] [26B-3-1018](#); and

5390 (c) (i) the individual does not file a timely request for review of the department's
5391 decision under Title 63G, Chapter 4, Administrative Procedures Act; or

5392 (ii) the department's decision is upheld upon final review or appeal under Title 63G,
5393 Chapter 4, Administrative Procedures Act.

5394 Section 148. Section **26B-3-1016**, which is renumbered from Section 26-19-502 is
5395 renumbered and amended to read:

5396 [~~26-19-502~~]. **26B-3-1016. Presumption of permanency.**

5397 There is a rebuttable presumption that an individual who is an inpatient in a care facility
5398 cannot reasonably be expected to be discharged from a care facility and return to the
5399 individual's home, if the individual has been an inpatient in a care facility for a period of at
5400 least 180 consecutive days.

5401 Section 149. Section **26B-3-1017**, which is renumbered from Section 26-19-503 is

5402 renumbered and amended to read:

5403 ~~[26-19-503].~~ 26B-3-1017. Preliminary notice of intent to impose a TEFRA
5404 **lien.**

5405 (1) Prior to imposing a TEFRA lien on real property, the department shall serve a
5406 preliminary notice of intent to impose a TEFRA lien, on the individual described in Subsection
5407 ~~[26-19-501]~~ 26B-3-1015(1), who owns the property.

5408 (2) The preliminary notice of intent shall:

5409 (a) be served in person, or by certified mail, on the individual described in Subsection
5410 ~~[26-19-501]~~ 26B-3-1015(1), and, if the department is aware that the individual has a legally
5411 authorized representative, on the representative;

5412 (b) include a statement indicating that, according to the department's records, the
5413 individual:

5414 (i) meets the criteria described in Subsections ~~[26-19-501]~~ 26B-3-1015(1)(a) and (b);

5415 (ii) has been an inpatient in a care facility for a period of at least 180 days immediately
5416 preceding the day on which the department provides the notice to the individual; and

5417 (iii) is legally presumed to be in a condition where it cannot reasonably be expected
5418 that the individual will be discharged from the care facility and return to the individual's home;

5419 (c) indicate that the department intends to impose a TEFRA lien on real property
5420 belonging to the individual;

5421 (d) describe the real property that the TEFRA lien will apply to;

5422 (e) describe the current amount of, and purpose of, the TEFRA lien;

5423 (f) indicate that the amount of the lien may continue to increase as the individual
5424 continues to receive medical assistance;

5425 (g) indicate that the individual may seek to prevent the TEFRA lien from being
5426 imposed on the real property by providing documentation to the department that:

5427 (i) establishes that the individual does not meet the criteria described in Subsection
5428 ~~[26-19-501]~~ 26B-3-1015(1)(a) or (b);

- 5429 (ii) establishes that the individual has not been an inpatient in a care facility for a
5430 period of at least 180 days;
- 5431 (iii) rebuts the presumption described in Section [~~26-19-502~~] [26B-3-1016](#); or
- 5432 (iv) establishes that the real property is exempt from imposition of a TEFRA lien under
5433 Subsection [~~26-19-501~~] [26B-3-1015](#)(2);
- 5434 (h) indicate that if the owner fails to provide the documentation described in
5435 Subsection (2)(g) within 30 days after the day on which the preliminary notice of intent is
5436 served, the department will issue a final notice of intent to impose a TEFRA lien on the real
5437 property and will proceed to impose the lien;
- 5438 (i) identify the type of documentation that the owner may provide to comply with
5439 Subsection (2)(g);
- 5440 (j) describe the circumstances under which a TEFRA lien is required to be released;
5441 and
- 5442 (k) describe the circumstances under which the department may seek to recover the
5443 lien.

5444 Section 150. Section **26B-3-1018**, which is renumbered from Section 26-19-504 is
5445 renumbered and amended to read:

5446 [~~26-19-504~~]. **26B-3-1018. Final notice of intent to impose a TEFRA lien.**

5447 (1) The department may issue a final notice of intent to impose a TEFRA lien on real
5448 property if:

5449 (a) a preliminary notice of intent relating to the property is served in accordance with
5450 Section [~~26-19-503~~] [26B-3-1017](#);

5451 (b) it is at least 30 days after the day on which the preliminary notice of intent was
5452 served; and

5453 (c) the department has not received documentation or other evidence that adequately
5454 establishes that a TEFRA lien may not be imposed on the real property.

5455 (2) The final notice of intent to impose a TEFRA lien on real property shall:

- 5456 (a) be served in person, or by certified mail, on the individual described in Subsection
5457 [~~26-19-501~~] 26B-3-1015(1), who owns the property, and, if the department is aware that the
5458 individual has a legally authorized representative, on the representative;
- 5459 (b) indicate that the department has complied with the requirements for filing the final
5460 notice of intent under Subsection (1);
- 5461 (c) include a statement indicating that, according to the department's records, the
5462 individual:
- 5463 (i) meets the criteria described in Subsections [~~26-19-501~~] 26B-3-1015(1)(a) and (b);
5464 (ii) has been an inpatient in a care facility for a period of at least 180 days immediately
5465 preceding the day on which the department provides the notice to the individual; and
5466 (iii) is legally presumed to be in a condition where it cannot reasonably be expected
5467 that the individual will be discharged from the care facility and return to the individual's home;
- 5468 (d) indicate that the department intends to impose a TEFRA lien on real property
5469 belonging to the individual;
- 5470 (e) describe the real property that the TEFRA lien will apply to;
- 5471 (f) describe the current amount of, and purpose of, the TEFRA lien;
- 5472 (g) indicate that the amount of the lien may continue to increase as the individual
5473 continues to receive medical assistance;
- 5474 (h) describe the circumstances under which a TEFRA lien is required to be released;
- 5475 (i) describe the circumstances under which the department may seek to recover the
5476 lien;
- 5477 (j) describe the right of the individual to challenge the decision of the department in an
5478 adjudicative proceeding; and
- 5479 (k) indicate that failure by the individual to successfully challenge the decision of the
5480 department will result in the TEFRA lien being imposed.

5481 Section 151. Section **26B-3-1019**, which is renumbered from Section 26-19-505 is
5482 renumbered and amended to read:

5483 ~~[26-19-505]~~. **26B-3-1019. Review of department decision.**

5484 An individual who has been served with a final notice of intent to impose a TEFRA lien
5485 under Section ~~[26-19-504]~~ 26B-3-1018 may seek agency or judicial review of that decision
5486 under Title 63G, Chapter 4, Administrative Procedures Act.

5487 Section 152. Section **26B-3-1020**, which is renumbered from Section 26-19-506 is
5488 renumbered and amended to read:

5489 ~~[26-19-506]~~. **26B-3-1020. Dissolution and removal of TEFRA lien.**

5490 (1) A TEFRA lien shall dissolve and be removed by the department if the individual
5491 described in Subsection ~~[26-19-501]~~ 26B-3-1015(1):

5492 (a) (i) is discharged from the care facility; and

5493 (ii) returns to the individual's home; or

5494 (b) provides sufficient documentation to the department that:

5495 (i) rebuts the presumption described in Section ~~[26-19-502]~~ 26B-3-1016; or

5496 (ii) any of the following individuals are lawfully residing in the individual's home:

5497 (A) the spouse of the individual;

5498 (B) a child of the individual, if the child is under 21 years ~~[of age]~~ old or blind or
5499 permanently and totally disabled, as defined in Title 42 U.S.C. Sec. 1382c(a)(3)(F); or

5500 (C) a sibling of the individual, if the sibling has an equity interest in the home and
5501 resided in the home for at least one year immediately preceding the day on which the individual
5502 was admitted to the care facility.

5503 (2) An individual described in Subsection ~~[26-19-501]~~ 26B-3-1015(1)(a) may, at any
5504 time after the department has imposed a lien under ~~[this part]~~ Sections 26B-3-1015 through
5505 26B-3-1023, file a request for the department to remove the lien.

5506 (3) A request filed under Subsection (2) shall be considered and reviewed pursuant to
5507 Title 63G, Chapter 4, Administrative Procedures Act.

5508 Section 153. Section **26B-3-1021**, which is renumbered from Section 26-19-507 is
5509 renumbered and amended to read:

5510 ~~[26-19-507]~~. **26B-3-1021. Expenditures included in lien -- Other**
5511 **proceedings.**

5512 (1) A TEFRA lien imposed on real property under ~~[this part]~~ Sections 26B-3-1015
5513 through 26B-3-1023 includes all expenses relating to medical assistance provided or paid for
5514 under the state plan from the first day that the individual is placed in a care facility, regardless
5515 of when the lien is imposed or filed on the property.

5516 (2) Nothing in ~~[this part affects or prevents]~~ Sections 26B-3-1015 through 26B-3-1023
5517 affect or prevent the department from bringing or pursuing any other legally authorized action
5518 to recover medical assistance or to set aside a fraudulent or improper conveyance.

5519 Section 154. Section **26B-3-1022**, which is renumbered from Section 26-19-508 is
5520 renumbered and amended to read:

5521 ~~[26-19-508]~~. **26B-3-1022. Contract with another government agency.**

5522 If the department contracts with another government agency to recover funds paid for
5523 medical assistance under this ~~[chapter]~~ part, that government agency shall be the sole agency
5524 that determines whether to impose or remove a TEFRA lien under ~~[this part]~~ Sections
5525 26B-3-1015 through 26B-3-1023.

5526 Section 155. Section **26B-3-1023**, which is renumbered from Section 26-19-509 is
5527 renumbered and amended to read:

5528 ~~[26-19-509]~~. **26B-3-1023. Precedence of the Tax Equity and Fiscal**
5529 **Responsibility Act of 1982.**

5530 If any provision of ~~[this part conflicts]~~ Sections 26B-3-1015 through 26B-3-1023
5531 conflict with the requirements of the Tax Equity and Fiscal Responsibility Act of 1982 for
5532 imposing a lien against the property of an individual prior to the individual's death, under 42
5533 U.S.C. Sec. 1396p, the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 take
5534 precedence and shall be complied with by the department.

5535 Section 156. Section **26B-3-1024**, which is renumbered from Section 26-19-601 is
5536 renumbered and amended to read:

5537 ~~[26-19-601]~~. 26B-3-1024. **Legal recognition of electronic claims records.**

5538 Pursuant to Title 46, Chapter 4, Uniform Electronic Transactions Act:

5539 (1) a claim submitted to the department for payment may not be denied legal effect,
5540 enforceability, or admissibility as evidence in any court in any civil action because it is in
5541 electronic form; and

5542 (2) a third party shall accept an electronic record of payments by the department for
5543 medical services on behalf of a recipient as evidence in support of the department's claim.

5544 Section 157. Section **26B-3-1025**, which is renumbered from Section 26-19-602 is
5545 renumbered and amended to read:

5546 ~~[26-19-602]~~. 26B-3-1025. **Direct payment to the department by third**
5547 **party.**

5548 (1) Any third party required to make payment to the department pursuant to this
5549 ~~[chapter]~~ part shall make the payment directly to the department or its designee.

5550 (2) The department may negotiate a payment or payment instrument it receives in
5551 connection with Subsection (1) without the cosignature or other participation of the recipient or
5552 any other party.

5553 Section 158. Section **26B-3-1026**, which is renumbered from Section 26-19-603 is
5554 renumbered and amended to read:

5555 ~~[26-19-603]~~. 26B-3-1026. **Attorney general or county attorney to**
5556 **represent department.**

5557 The attorney general or a county attorney shall represent the department in any action
5558 commenced under this ~~[chapter]~~ part.

5559 Section 159. Section **26B-3-1027**, which is renumbered from Section 26-19-604 is
5560 renumbered and amended to read:

5561 ~~[26-19-604]~~. 26B-3-1027. **Department's right to attorney fees and costs.**

5562 In any action brought by the department under this ~~[chapter]~~ part in which it prevails,
5563 the department shall recover along with the principal sum and interest, a reasonable attorney

5564 fee and costs incurred.

5565 Section 160. Section **26B-3-1028**, which is renumbered from Section 26-19-605 is
5566 renumbered and amended to read:

5567 ~~[26-19-605]~~. **26B-3-1028**. **Application of provisions contrary to federal**
5568 **law prohibited.**

5569 In no event shall any provision contained in this [~~chapter~~] part be applied contrary to
5570 existing federal law.

5571 Section 161. Section **26B-3-1101**, which is renumbered from Section 26-20-2 is
5572 renumbered and amended to read:

5573 **Part 11. Utah False Claims Act**

5574 ~~[26-20-2]~~. **26B-3-1101**. **Definitions.**

5575 As used in this [~~chapter~~] part:

5576 (1) "Benefit" means the receipt of money, goods, or any other thing of pecuniary value.

5577 (2) "Claim" means any request or demand for money or property:

5578 (a) made to any:

5579 (i) employee, officer, or agent of the state;

5580 (ii) contractor with the state; or

5581 (iii) grantee or other recipient, whether or not under contract with the state; and

5582 (b) if:

5583 (i) any portion of the money or property requested or demanded was issued from or
5584 provided by the state; or

5585 (ii) the state will reimburse the contractor, grantee, or other recipient for any portion of
5586 the money or property.

5587 (3) "False statement" or "false representation" means a wholly or partially untrue
5588 statement or representation which is:

5589 (a) knowingly made; and

5590 (b) a material fact with respect to the claim.

5591 (4) "Knowing" and "knowingly":

5592 (a) for purposes of criminal prosecutions for violations of this [chapter] part, is one of
5593 the culpable mental states described in Subsection [~~26-20-9~~] 26B-3-1108(1); and

5594 (b) for purposes of civil prosecutions for violations of this [chapter] part, is the
5595 required culpable mental state as defined in Subsection [~~26-20-9.5~~] 26B-3-1109(1).

5596 (5) "Medical benefit" means a benefit paid or payable to a recipient or a provider under
5597 a program administered by the state under:

5598 (a) Titles V and XIX of the federal Social Security Act;

5599 (b) Title X of the federal Public Health Services Act;

5600 (c) the federal Child Nutrition Act of 1966 as amended by [~~P.L.~~] Pub. L. No. 94-105;

5601 and

5602 (d) any programs for medical assistance of the state.

5603 (6) "Person" means an individual, corporation, unincorporated association, professional
5604 corporation, partnership, or other form of business association.

5605 Section 162. Section **26B-3-1102**, which is renumbered from Section 26-20-3 is
5606 renumbered and amended to read:

5607 ~~[26-20-3]~~. **26B-3-1102. False statement or representation relating to medical**
5608 **benefits.**

5609 (1) A person may not make or cause to be made a false statement or false representation
5610 of a material fact in an application for medical benefits.

5611 (2) A person may not make or cause to be made a false statement or false
5612 representation of a material fact for use in determining rights to a medical benefit.

5613 (3) A person, who having knowledge of the occurrence of an event affecting the
5614 person's initial or continued right to receive a medical benefit or the initial or continued right of
5615 any other person on whose behalf the person has applied for or is receiving a medical benefit,
5616 may not conceal or fail to disclose that event with intent to obtain a medical benefit to which
5617 the person or any other person is not entitled or in an amount greater than that to which the

5618 person or any other person is entitled.

5619 Section 163. Section **26B-3-1103**, which is renumbered from Section 26-20-4 is
5620 renumbered and amended to read:

5621 ~~[26-20-4]~~. **26B-3-1103. Kickbacks or bribes prohibited.**

5622 (1) For purposes of this section, kickback or bribe:

5623 (a) includes rebates, compensation, or any other form of remuneration which is:

5624 (i) direct or indirect;

5625 (ii) overt or covert; or

5626 (iii) in cash or in kind; and

5627 (b) does not include a rebate paid to the state under 42 U.S.C. Sec. 1396r-8 or any state
5628 supplemental rebates.

5629 (2) A person may not solicit, offer, pay, or receive a kickback or bribe in return for or
5630 to induce:

5631 (a) the purchasing, leasing, or ordering of any goods or services for which payment is
5632 or may be made in whole or in part pursuant to a medical benefit program; or

5633 (b) the referral of an individual to another person for the furnishing of any goods or
5634 services for which payment is or may be made in whole or in part pursuant to a medical benefit
5635 program.

5636 Section 164. Section **26B-3-1104**, which is renumbered from Section 26-20-5 is
5637 renumbered and amended to read:

5638 ~~[26-20-5]~~. **26B-3-1104. False statements or false representations relating to
5639 qualification of health institution or facility prohibited -- Felony.**

5640 (1) A person may not knowingly, intentionally, or recklessly make, induce, or seek to
5641 induce, the making of a false statement or false representation of a material fact with respect to
5642 the conditions or operation of an institution or facility in order that the institution or facility
5643 may qualify, upon initial certification or upon recertification, as a hospital, skilled nursing
5644 facility, intermediate care facility, or home health agency.

5645 (2) A person who violates this section is guilty of a second degree felony.

5646 Section 165. Section **26B-3-1105**, which is renumbered from Section 26-20-6 is
5647 renumbered and amended to read:

5648 ~~[26-20-6]~~. **26B-3-1105. Conspiracy to defraud prohibited.**

5649 A person may not enter into an agreement, combination, or conspiracy to defraud the
5650 state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious, or
5651 fraudulent claim for a medical benefit.

5652 Section 166. Section **26B-3-1106**, which is renumbered from Section 26-20-7 is
5653 renumbered and amended to read:

5654 ~~[26-20-7]~~. **26B-3-1106. False claims for medical benefits prohibited.**

5655 (1) A person may not make or present or cause to be made or presented to an employee
5656 or officer of the state a claim for a medical benefit:

5657 (a) which is wholly or partially false, fictitious, or fraudulent;

5658 (b) for services which were not rendered or for items or materials which were not
5659 delivered;

5660 (c) which misrepresents the type, quality, or quantity of items or services rendered;

5661 (d) representing charges at a higher rate than those charged by the provider to the
5662 general public;

5663 (e) for items or services which the person or the provider knew were not medically
5664 necessary in accordance with professionally recognized standards;

5665 (f) which has previously been paid;

5666 (g) for services also covered by one or more private sources when the person or
5667 provider knew of the private sources without disclosing those sources on the claim; or

5668 (h) where a provider:

5669 (i) unbundles a product, procedure, or group of procedures usually and customarily
5670 provided or performed as a single billable product or procedure into artificial components or
5671 separate procedures; and

5672 (ii) bills for each component of the product, procedure, or group of procedures:
5673 (A) as if they had been provided or performed independently and at separate times; and
5674 (B) the aggregate billing for the components exceeds the amount otherwise billable for
5675 the usual and customary single product or procedure.

5676 (2) In addition to the prohibitions in Subsection (1), a person may not:
5677 (a) fail to credit the state for payments received from other sources;
5678 (b) recover or attempt to recover payment in violation of the provider agreement from:
5679 (i) a recipient under a medical benefit program; or
5680 (ii) the recipient's family;
5681 (c) falsify or alter with intent to deceive, any report or document required by state or
5682 federal law, rule, or Medicaid provider agreement;
5683 (d) retain any unauthorized payment as a result of acts described by this section; or
5684 (e) aid or abet the commission of any act prohibited by this section.

5685 Section 167. Section **26B-3-1107**, which is renumbered from Section 26-20-8 is
5686 renumbered and amended to read:

5687 **[26-20-8]. 26B-3-1107. Knowledge of past acts not necessary to establish fact**
5688 **that false statement or representation knowingly made.**

5689 In prosecution under this ~~chapter~~ part, it is not necessary to show that the person had
5690 knowledge of similar acts having been performed in the past on the part of persons acting on
5691 his behalf nor to show that the person had actual notice that the acts by the persons acting on
5692 his behalf occurred to establish the fact that a false statement or representation was knowingly
5693 made.

5694 Section 168. Section **26B-3-1108**, which is renumbered from Section 26-20-9 is
5695 renumbered and amended to read:

5696 **[26-20-9]. 26B-3-1108. Criminal penalties.**

5697 (1) (a) Except as provided in Subsection (1)(b) the culpable mental state required for a
5698 criminal violation of this ~~chapter~~ part is knowingly, intentionally, or recklessly as defined in

5699 Section 76-2-103.

5700 (b) The culpable mental state required for a criminal violation of this [chapter] part for
5701 kickbacks and bribes under Section [~~26-20-4~~] 26B-3-1103 is knowingly and intentionally as
5702 defined in Section 76-2-103.

5703 (2) The punishment for a criminal violation of any provision of this [chapter] part,
5704 except as provided under Section [~~26-20-5~~] 26B-3-1104, is determined by the cumulative value
5705 of the funds or other benefits received or claimed in the commission of all violations of a
5706 similar nature, and not by each separate violation.

5707 (3) Punishment for criminal violation of this [chapter] part, except as provided under
5708 Section [~~26-20-5~~] 26B-3-1104, is a felony of the second degree, felony of the third degree,
5709 class A misdemeanor, or class B misdemeanor based on the dollar amounts as prescribed by
5710 Subsection 76-6-412(1) for theft of property and services.

5711 Section 169. Section **26B-3-1109**, which is renumbered from Section 26-20-9.5 is
5712 renumbered and amended to read:

5713 ~~[26-20-9.5].~~ **26B-3-1109. Civil penalties.**

5714 (1) The culpable mental state required for a civil violation of this [chapter] part is
5715 "knowing" or "knowingly" which:

5716 (a) means that person, with respect to information:

5717 (i) has actual knowledge of the information;

5718 (ii) acts in deliberate ignorance of the truth or falsity of the information; or

5719 (iii) acts in reckless disregard of the truth or falsity of the information; and

5720 (b) does not require a specific intent to defraud.

5721 (2) Any person who violates this [chapter] part shall, in all cases, in addition to other
5722 penalties provided by law, be required to:

5723 (a) make full and complete restitution to the state of all damages that the state sustains
5724 because of the person's violation of this [chapter] part;

5725 (b) pay to the state its costs of enforcement of this [chapter] part in that case, including

5726 the cost of investigators, attorneys, and other public employees, as determined by the state; and

5727 (c) pay to the state a civil penalty equal to:

5728 (i) three times the amount of damages that the state sustains because of the person's
5729 violation of this [~~chapter~~] part; and

5730 (ii) not less than \$5,000 or more than \$10,000 for each claim filed or act done in
5731 violation of this [~~chapter~~] part.

5732 (3) Any civil penalties assessed under Subsection (2) shall be awarded by the court as
5733 part of its judgment in both criminal and civil actions.

5734 (4) A criminal action need not be brought against a person in order for that person to be
5735 civilly liable under this section.

5736 Section 170. Section **26B-3-1110**, which is renumbered from Section 26-20-10 is
5737 renumbered and amended to read:

5738 [~~26-20-10~~]. **26B-3-1110**. **Revocation of license of assisted living facility --**

5739 **Appointment of receiver.**

5740 (1) If the license of an assisted living facility is revoked for violation of this [~~chapter~~]
5741 part, the county attorney may file a petition with the district court for the county in which the
5742 facility is located for the appointment of a receiver.

5743 (2) The district court shall issue an order to show cause why a receiver should not be
5744 appointed returnable within five days after the filing of the petition.

5745 (3) (a) If the court finds that the facts warrant the granting of the petition, the court
5746 shall appoint a receiver to take charge of the facility.

5747 (b) The court may determine fair compensation for the receiver.

5748 (4) A receiver appointed pursuant to this section shall have the powers and duties
5749 prescribed by the court.

5750 Section 171. Section **26B-3-1111**, which is renumbered from Section 26-20-11 is
5751 renumbered and amended to read:

5752 [~~26-20-11~~]. **26B-3-1111**. **Presumption based on paid state warrant -- Value of**

5753 **medical benefits -- Repayment of benefits.**

5754 (1) In any civil or criminal action brought under this [chapter] part, a paid state
5755 warrant, made payable to the order of a party, creates a presumption that the party received
5756 funds from the state.

5757 (2) In any civil or criminal action brought under this [chapter] part, the value of the
5758 benefits received shall be the ordinary or usual charge for similar benefits in the private sector.

5759 (3) In any criminal action under this [chapter] part, the repayment of funds or other
5760 benefits obtained in violation of the provisions of this [chapter] part does not constitute a
5761 defense to, or grounds for dismissal of that action.

5762 Section 172. Section **26B-3-1112**, which is renumbered from Section 26-20-12 is
5763 renumbered and amended to read:

5764 ~~[26-20-12]~~. **26B-3-1112. Violation of other laws.**

5765 (1) The provisions of this [chapter] part are:

5766 (a) not exclusive, and the remedies provided for in this [chapter] part are in addition to
5767 any other remedies provided for under:

5768 (i) any other applicable law; or

5769 (ii) common law; and

5770 (b) to be liberally construed and applied to:

5771 (i) effectuate the chapter's remedial and deterrent purposes; and

5772 (ii) serve the public interest.

5773 (2) If any provision of this [chapter] part or the application of this [chapter] part to any
5774 person or circumstance is held unconstitutional:

5775 (a) the remaining provisions of this [chapter] part are not affected; and

5776 (b) the application of this [chapter] part to other persons or circumstances are not
5777 affected.

5778 Section 173. Section **26B-3-1113**, which is renumbered from Section 26-20-13 is
5779 renumbered and amended to read:

5780 ~~[26-20-13]~~. **26B-3-1113. Medicaid fraud enforcement.**

5781 (1) This ~~[chapter]~~ part shall be enforced in accordance with this section.

5782 (2) The department is responsible for:

5783 (a) (i) investigating and prosecuting suspected civil violations of this ~~[chapter]~~ part; or

5784 (ii) referring suspected civil violations of this ~~[chapter]~~ part to the attorney general for
5785 investigation and prosecution; and

5786 (b) promptly referring suspected criminal violations of this ~~[chapter]~~ part to the
5787 attorney general for criminal investigation and prosecution.

5788 (3) The attorney general has:

5789 (a) concurrent jurisdiction with the department for investigating and prosecuting
5790 suspected civil violations of this ~~[chapter]~~ part; and

5791 (b) exclusive jurisdiction to investigate and prosecute all suspected criminal violations
5792 of this ~~[chapter]~~ part.

5793 (4) The department and the attorney general share concurrent civil enforcement
5794 authority under this ~~[chapter]~~ part and may enter into an interagency agreement regarding the
5795 investigation and prosecution of violations of this ~~[chapter]~~ part in accordance with this
5796 section, the requirements of Title XIX of the federal Social Security Act, and applicable federal
5797 regulations.

5798 (5) (a) Any violation of this ~~[chapter]~~ part which comes to the attention of any state
5799 government officer or agency shall be reported to the attorney general or the department.

5800 (b) All state government officers and agencies shall cooperate with and assist in any
5801 prosecution for violation of this ~~[chapter]~~ part.

5802 Section 174. Section **26B-3-1114**, which is renumbered from Section 26-20-14 is
5803 renumbered and amended to read:

5804 ~~[26-20-14]~~. **26B-3-1114. Investigations -- Civil investigative demands.**

5805 (1) The attorney general may take investigative action under Subsection (2) if the
5806 attorney general has reason to believe that:

5807 (a) a person has information or custody or control of documentary material relevant to
5808 the subject matter of an investigation of an alleged violation of this [chapter] part;

5809 (b) a person is committing, has committed, or is about to commit a violation of this
5810 [chapter] part; or

5811 (c) it is in the public interest to conduct an investigation to ascertain whether or not a
5812 person is committing, has committed, or is about to commit a violation of this [chapter] part.

5813 (2) In taking investigative action, the attorney general may:

5814 (a) require the person to file on a prescribed form a statement in writing, under oath or
5815 affirmation describing:

5816 (i) the facts and circumstances concerning the alleged violation of this [chapter] part;
5817 and

5818 (ii) other information considered necessary by the attorney general;

5819 (b) examine under oath a person in connection with the alleged violation of this
5820 [chapter] part; and

5821 (c) in accordance with Subsections (7) through (18), execute in writing, and serve on
5822 the person, a civil investigative demand requiring the person to produce the documentary
5823 material and permit inspection and copying of the material.

5824 (3) The attorney general may not release or disclose information that is obtained under
5825 Subsection (2)(a) or (b), or any documentary material or other record derived from the
5826 information obtained under Subsection (2)(a) or (b), except:

5827 (a) by court order for good cause shown;

5828 (b) with the consent of the person who provided the information;

5829 (c) to an employee of the attorney general or the department;

5830 (d) to an agency of this state, the United States, or another state;

5831 (e) to a special assistant attorney general representing the state in a civil action;

5832 (f) to a political subdivision of this state; or

5833 (g) to a person authorized by the attorney general to receive the information.

5834 (4) The attorney general may use documentary material derived from information
5835 obtained under Subsection (2)(a) or (b), or copies of that material, as the attorney general
5836 determines necessary in the enforcement of this [chapter] part, including presentation before a
5837 court.

5838 (5) (a) If a person fails to file a statement as required by Subsection (2)(a) or fails to
5839 submit to an examination as required by Subsection (2)(b), the attorney general may file in
5840 district court a complaint for an order to compel the person to within a period stated by court
5841 order:

5842 (i) file the statement required by Subsection (2)(a); or

5843 (ii) submit to the examination required by Subsection (2)(b).

5844 (b) Failure to comply with an order entered under Subsection (5)(a) is punishable as
5845 contempt.

5846 (6) A civil investigative demand shall:

5847 (a) state the rule or statute under which the alleged violation of this [chapter] part is
5848 being investigated;

5849 (b) describe the:

5850 (i) general subject matter of the investigation; and

5851 (ii) class or classes of documentary material to be produced with reasonable specificity
5852 to fairly indicate the documentary material demanded;

5853 (c) designate a date within which the documentary material is to be produced; and

5854 (d) identify an authorized employee of the attorney general to whom the documentary
5855 material is to be made available for inspection and copying.

5856 (7) A civil investigative demand may require disclosure of any documentary material
5857 that is discoverable under the Utah Rules of Civil Procedure.

5858 (8) Service of a civil investigative demand may be made by:

5859 (a) delivering an executed copy of the demand to the person to be served or to a
5860 partner, an officer, or an agent authorized by appointment or by law to receive service of

5861 process on behalf of that person;

5862 (b) delivering an executed copy of the demand to the principal place of business in this
5863 state of the person to be served; or

5864 (c) mailing by registered or certified mail an executed copy of the demand addressed to
5865 the person to be served:

5866 (i) at the person's principal place of business in this state; or

5867 (ii) if the person has no place of business in this state, to the person's principal office or
5868 place of business.

5869 (9) Documentary material demanded in a civil investigative demand shall be produced
5870 for inspection and copying during normal business hours at the office of the attorney general or
5871 as agreed by the person served and the attorney general.

5872 (10) The attorney general may not produce for inspection or copying or otherwise
5873 disclose the contents of documentary material obtained pursuant to a civil investigative demand
5874 except:

5875 (a) by court order for good cause shown;

5876 (b) with the consent of the person who produced the information;

5877 (c) to an employee of the attorney general or the department;

5878 (d) to an agency of this state, the United States, or another state;

5879 (e) to a special assistant attorney general representing the state in a civil action;

5880 (f) to a political subdivision of this state; or

5881 (g) to a person authorized by the attorney general to receive the information.

5882 (11) (a) With respect to documentary material obtained pursuant to a civil investigative
5883 demand, the attorney general shall prescribe reasonable terms and conditions allowing such
5884 documentary material to be available for inspection and copying by the person who produced
5885 the material or by an authorized representative of that person.

5886 (b) The attorney general may use such documentary material or copies of it as the
5887 attorney general determines necessary in the enforcement of this ~~chapter~~ part, including

5888 presentation before a court.

5889 (12) (a) A person may file a complaint, stating good cause, to extend the return date for
5890 the demand or to modify or set aside the demand.

5891 (b) A complaint under this Subsection (12) shall be filed in district court before the
5892 earlier of:

5893 ~~[(a)]~~ (i) the return date specified in the demand; or

5894 ~~[(b)]~~ (ii) the 20th day after the date the demand is served.

5895 (13) Except as provided by court order, a person who has been served with a civil
5896 investigative demand shall comply with the terms of the demand.

5897 (14) (a) A person who has committed a violation of this ~~[chapter]~~ part in relation to the
5898 Medicaid program in this state or to any other medical benefit program administered by the
5899 state has submitted to the jurisdiction of this state.

5900 (b) Personal service of a civil investigative demand under this section may be made on
5901 the person described in Subsection (14)(a) outside of this state.

5902 (15) This section does not limit the authority of the attorney general to conduct
5903 investigations or to access a person's documentary materials or other information under another
5904 state or federal law, the Utah Rules of Civil Procedure, or the Federal Rules of Civil Procedure.

5905 (16) The attorney general may file a complaint in district court for an order to enforce
5906 the civil investigative demand if:

5907 (a) a person fails to comply with a civil investigative demand; or

5908 (b) copying and reproduction of the documentary material demanded:

5909 (i) cannot be satisfactorily accomplished; and

5910 (ii) the person refuses to surrender the documentary material.

5911 (17) If a complaint is filed under Subsection (16), the court may determine the matter
5912 presented and may enter an order to enforce the civil investigative demand.

5913 (18) Failure to comply with a final order entered under Subsection (17) is punishable
5914 by contempt.

5915 Section 175. Section **26B-3-1115**, which is renumbered from Section 26-20-15 is
5916 renumbered and amended to read:

5917 ~~[26-20-15]~~. **26B-3-1115. Limitation of actions -- Civil acts antedating this**
5918 **section -- Civil burden of proof -- Estoppel -- Joint civil liability -- Venue.**

5919 (1) An action under this [chapter] part may not be brought after the later of:

5920 (a) six years after the date on which the violation was committed; or

5921 (b) three years after the date an official of the state charged with responsibility to act in
5922 the circumstances discovers the violation, but in no event more than 10 years after the date on
5923 which the violation was committed.

5924 (2) A civil action brought under this [chapter] part may be brought for acts occurring
5925 prior to the effective date of this section if the limitations period set forth in Subsection (1) has
5926 not lapsed.

5927 (3) In any civil action brought under this [chapter] part the state shall be required to
5928 prove by a preponderance of evidence, all essential elements of the cause of action including
5929 damages.

5930 (4) Notwithstanding any other provision of law, a final judgment rendered in favor of
5931 the state in any criminal proceeding under this [chapter] part, whether upon a verdict after trial
5932 or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential
5933 elements of the offense in any civil action under this [chapter] part which involves the same
5934 transaction.

5935 (5) Civil liability under this [chapter] part shall be joint and several for a violation
5936 committed by two or more persons.

5937 (6) Any action brought by the state under this [chapter] part shall be brought in district
5938 court in Salt Lake County or in any county where the defendant resides or does business.

5939 Section 176. Section **26B-8-101** is amended to read:

5940 **CHAPTER 8. HEALTH DATA, VITAL STATISTICS, AND UTAH MEDICAL**
5941 **EXAMINER**

Part 1. Vital Statistics

5942
5943
5944
5945
5946
5947
5948
5949
5950
5951
5952
5953
5954
5955
5956
5957
5958
5959
5960
5961
5962
5963
5964
5965
5966
5967
5968

26B-8-101. Definitions.

[Reserved]

As used in this part:

(1) "Adoption document" means an adoption-related document filed with the office, a petition for adoption, a decree of adoption, an original birth certificate, or evidence submitted in support of a supplementary birth certificate.

(2) "Certified nurse midwife" means an individual who:

(a) is licensed to practice as a certified nurse midwife under Title 58, Chapter 44a, Nurse Midwife Practice Act; and

(b) has completed an education program regarding the completion of a certificate of death developed by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Custodial funeral service director" means a funeral service director who:

(a) is employed by a licensed funeral establishment; and

(b) has custody of a dead body.

(4) "Dead body" means a human body or parts of a human body from the condition of which it reasonably may be concluded that death occurred.

(5) "Decedent" means the same as a dead body.

(6) "Dead fetus" means a product of human conception, other than those circumstances described in Subsection [76-7-301\(1\)](#):

(a) of 20 weeks' gestation or more, calculated from the date the last normal menstrual period began to the date of delivery; and

(b) that was not born alive.

(7) "Declarant father" means a male who claims to be the genetic father of a child, and, along with the biological mother, signs a voluntary declaration of paternity to establish the child's paternity.

- 5969 (8) "Dispositioner" means:
5970 (a) a person designated in a written instrument, under Subsection [58-9-602\(1\)](#), as
5971 having the right and duty to control the disposition of the decedent, if the person voluntarily
5972 acts as the dispositioner; or
5973 (b) the next of kin of the decedent, if:
5974 (i) (A) a person has not been designated as described in Subsection (8)(a); or
5975 (B) the person described in Subsection (8)(a) is unable or unwilling to exercise the
5976 right and duty described in Subsection (8)(a); and
5977 (ii) the next of kin voluntarily acts as the dispositioner.
5978 (9) "Fetal remains" means:
5979 (a) an aborted fetus as that term is defined in Section [26B-2-232](#); or
5980 (b) a miscarried fetus as that term is defined in Section [26B-2-233](#).
5981 (10) "File" means the submission of a completed certificate or other similar document,
5982 record, or report as provided under this part for registration by the state registrar or a local
5983 registrar.
5984 (11) "Funeral service director" means the same as that term is defined in Section
5985 [58-9-102](#).
5986 (12) "Health care facility" means the same as that term is defined in Section
5987 [26B-2-201](#).
5988 (13) "Health care professional" means a physician, physician assistant, nurse
5989 practitioner, or certified nurse midwife.
5990 (14) "Licensed funeral establishment" means:
5991 (a) if located in Utah, a funeral service establishment, as that term is defined in Section
5992 [58-9-102](#), that is licensed under Title 58, Chapter 9, Funeral Services Licensing Act; or
5993 (b) if located in a state, district, or territory of the United States other than Utah, a
5994 funeral service establishment that complies with the licensing laws of the jurisdiction where the
5995 establishment is located.

5996 (15) "Live birth" means the birth of a child who shows evidence of life after the child is
5997 entirely outside of the mother.

5998 (16) "Local registrar" means a person appointed under Subsection [26B-8-102\(3\)\(b\)](#).

5999 (17) "Nurse practitioner" means an individual who:

6000 (a) is licensed to practice as an advanced practice registered nurse under Title 58,
6001 Chapter 31b, Nurse Practice Act; and

6002 (b) has completed an education program regarding the completion of a certificate of
6003 death developed by the department by administrative rule made in accordance with Title 63G,
6004 Chapter 3, Utah Administrative Rulemaking Act.

6005 (18) "Office" means the Office of Vital Records and Statistics within the department.

6006 (19) "Physician" means a person licensed to practice as a physician or osteopath in this
6007 state under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah
6008 Osteopathic Medical Practice Act.

6009 (20) "Physician assistant" means an individual who:

6010 (a) is licensed to practice as a physician assistant under Title 58, Chapter 70a, Utah
6011 Physician Assistant Act; and

6012 (b) has completed an education program regarding the completion of a certificate of
6013 death developed by the department by administrative rule made in accordance with Title 63G,
6014 Chapter 3, Utah Administrative Rulemaking Act.

6015 (21) "Presumed father" means the father of a child conceived or born during a marriage
6016 as defined in Section [30-1-17.2](#).

6017 (22) "Registration" or "register" means acceptance by the local or state registrar of a
6018 certificate and incorporation of the certificate into the permanent records of the state.

6019 (23) "State registrar" means the state registrar of vital records appointed under Section
6020 [26B-8-102](#).

6021 (24) "Vital records" means:

6022 (a) registered certificates or reports of birth, death, fetal death, marriage, divorce,

6023 dissolution of marriage, or annulment;

6024 (b) amendments to any of the registered certificates or reports described in Subsection

6025 (24)(a);

6026 (c) an adoption document; and

6027 (d) other similar documents.

6028 (25) "Vital statistics" means the data derived from registered certificates and reports of

6029 birth, death, fetal death, induced termination of pregnancy, marriage, divorce, dissolution of

6030 marriage, or annulment.

6031 Section 177. Section **26B-8-102**, which is renumbered from Section 26-2-3 is

6032 renumbered and amended to read:

6033 ~~[26-2-3]~~. **26B-8-102. Department duties and authority.**

6034 (1) As used in this section:

6035 (a) "Compact" means the Compact for Interstate Sharing of Putative Father Registry

6036 Information created in Section [78B-6-121.5](#), effective on May 10, 2016.

6037 (b) "Putative father":

6038 (i) means the same as that term is as defined in Section [78B-6-121.5](#); and

6039 (ii) includes an unmarried biological father.

6040 (c) "State registrar" means the state registrar of vital records appointed under

6041 Subsection (2)(e).

6042 (d) "Unmarried biological father" means the same as that term is defined in Section

6043 [78B-6-103](#).

6044 (2) The department shall:

6045 (a) provide offices properly equipped for the preservation of vital records made or

6046 received under this ~~[chapter]~~ part;

6047 (b) establish a statewide vital records system for the registration, collection,

6048 preservation, amendment, and certification of vital records and other similar documents

6049 required by this ~~[chapter]~~ part and activities related to them, including the tabulation, analysis,

6050 and publication of vital statistics;

6051 (c) prescribe forms for certificates, certification, reports, and other documents and
6052 records necessary to establish and maintain a statewide system of vital records;

6053 (d) prepare an annual compilation, analysis, and publication of statistics derived from
6054 vital records; and

6055 (e) appoint a state registrar to direct the statewide system of vital records.

6056 (3) The department may:

6057 (a) divide the state from time to time into registration districts; and

6058 (b) appoint local registrars for registration districts who under the direction and
6059 supervision of the state registrar shall perform all duties required of them by this ~~chapter~~ part
6060 and department rules.

6061 (4) The state registrar appointed under Subsection (2)(e) shall, with the input of Utah
6062 stakeholders and the Uniform Law Commission, study the following items for the state's
6063 implementation of the compact:

6064 (a) the feasibility of using systems developed by the National Association for Public
6065 Health Statistics and Information Systems, including the State and Territorial Exchange of
6066 Vital Events (STEVE) system and the Electronic Verification of Vital Events (EVVE) system,
6067 or similar systems, to exchange putative father registry information with states that are parties
6068 to the compact;

6069 (b) procedures necessary to share putative father information, located in the
6070 confidential registry maintained by the state registrar, upon request from the state registrar of
6071 another state that is a party to the compact;

6072 (c) procedures necessary for the state registrar to access putative father information
6073 located in a state that is a party to the compact, and share that information with persons who
6074 request a certificate from the state registrar;

6075 (d) procedures necessary to ensure that the name of the mother of the child who is the
6076 subject of a putative father's notice of commencement, filed pursuant to Section 78B-6-121, is

6077 kept confidential when a state that is a party to the compact accesses this state's confidential
6078 registry through the state registrar; and

6079 (e) procedures necessary to ensure that a putative father's registration with a state that
6080 is a party to the compact is given the same effect as a putative father's notice of commencement
6081 filed pursuant to Section [78B-6-121](#).

6082 Section 178. Section **26B-8-103**, which is renumbered from Section 26-2-4 is
6083 renumbered and amended to read:

6084 ~~[26-2-4]~~. **26B-8-103**. **Content and form of certificates and reports.**

6085 (1) As used in this section:

6086 (a) "Additional information" means information that is beyond the information
6087 necessary to comply with federal standards or state law for registering a birth.

6088 (b) "Diacritical mark" means a mark on a letter from the ISO basic Latin alphabet used
6089 to indicate a special pronunciation.

6090 (c) "Diacritical mark" includes accents, tildes, graves, umlauts, and cedillas.

6091 (2) Except as provided in Subsection (8), to promote and maintain nationwide
6092 uniformity in the vital records system, the forms of certificates, certification, reports, and other
6093 documents and records required by this ~~[chapter]~~ part or the rules implementing this ~~[chapter]~~
6094 part shall include as a minimum the items recommended by the federal agency responsible for
6095 national vital statistics, subject to approval, additions, and modifications by the department.

6096 (3) Certificates, certifications, forms, reports, other documents and records, and the
6097 form of communications between persons required by this ~~[chapter]~~ part shall be prepared in
6098 the format prescribed by department rule.

6099 (4) All vital records shall include the date of filing.

6100 (5) Certificates, certifications, forms, reports, other documents and records, and
6101 communications between persons required by this ~~[chapter]~~ part may be signed, filed, verified,
6102 registered, and stored by photographic, electronic, or other means as prescribed by department
6103 rule.

6104 (6) (a) An individual may use a diacritical mark in an application for a vital record.

6105 (b) The office shall record a diacritical mark on a vital record as indicated on the
6106 application for the vital record.

6107 (7) The absence of a diacritical mark on a vital record does not render the document
6108 invalid or affect any constructive notice imparted by proper recordation of the document.

6109 (8) (a) The state:

6110 (i) may collect the Social Security number of a deceased individual; and

6111 (ii) may not include the Social Security number of an individual on a certificate of
6112 death.

6113 (b) For registering a birth, the department may not require an individual to provide
6114 additional information.

6115 (c) The department may request additional information if the department provides a
6116 written statement that:

6117 (i) discloses that providing the additional information is voluntary;

6118 (ii) discloses how the additional information will be used and the duration of use;

6119 (iii) describes how the department prevents the additional information from being used
6120 in a manner different from the disclosure given under Subsection [~~(6)(c)(ii)~~] (8)(c)(ii); and

6121 (iv) includes a notice that the individual is consenting to the department's use of the
6122 additional information by providing the additional information.

6123 (d) (i) Beginning July 1, 2022, an individual may submit a written request to the
6124 department to de-identify the individual's additional information contained in the department's
6125 databases.

6126 (ii) Upon receiving the written request, the department shall de-identify the additional
6127 information.

6128 (e) The department shall de-identify additional information contained in the
6129 department's databases before the additional information is held by the department for longer
6130 than six years.

6131 Section 179. Section **26B-8-104**, which is renumbered from Section 26-2-5 is
6132 renumbered and amended to read:

6133 ~~[26-2-5]~~. **26B-8-104**. **Birth certificates -- Execution and registration**
6134 **requirements.**

6135 (1) As used in this section, "birthing facility" means a general acute hospital or birthing
6136 center as defined in Section ~~[26-21-2]~~ 26B-2-201.

6137 (2) For each live birth occurring in the state, a certificate shall be filed with the local
6138 registrar for the district in which the birth occurred within 10 days following the birth. The
6139 certificate shall be registered if it is completed and filed in accordance with this ~~[chapter]~~ part.

6140 (3) (a) For each live birth that occurs in a birthing facility, the administrator of the
6141 birthing facility, or his designee, shall obtain and enter the information required under this
6142 ~~[chapter]~~ part on the certificate, securing the required signatures, and filing the certificate.

6143 (b) (i) The date, time, place of birth, and required medical information shall be certified
6144 by the birthing facility administrator or his designee.

6145 (ii) The attending physician or nurse midwife may sign the certificate, but if the
6146 attending physician or nurse midwife has not signed the certificate within seven days of the
6147 date of birth, the birthing facility administrator or his designee shall enter the attending
6148 physician's or nurse midwife's name and transmit the certificate to the local registrar.

6149 (iii) The information on the certificate about the parents shall be provided and certified
6150 by the mother or father or, in their incapacity or absence, by a person with knowledge of the
6151 facts.

6152 (4) (a) For live births that occur outside a birthing facility, the birth certificate shall be
6153 completed and filed by the physician, physician assistant, nurse, midwife, or other person
6154 primarily responsible for providing assistance to the mother at the birth. If there is no such
6155 person, either the presumed or declarant father shall complete and file the certificate. In his
6156 absence, the mother shall complete and file the certificate, and in the event of her death or
6157 disability, the owner or operator of the premises where the birth occurred shall do so.

6158 (b) The certificate shall be completed as fully as possible and shall include the date,
6159 time, and place of birth, the mother's name, and the signature of the person completing the
6160 certificate.

6161 (5) (a) For each live birth to an unmarried mother that occurs in a birthing facility, the
6162 administrator or director of that facility, or his designee, shall:

6163 (i) provide the birth mother and declarant father, if present, with:

6164 (A) a voluntary declaration of paternity form published by the state registrar;

6165 (B) oral and written notice to the birth mother and declarant father of the alternatives
6166 to, the legal consequences of, and the rights and responsibilities that arise from signing the
6167 declaration; and

6168 (C) the opportunity to sign the declaration;

6169 (ii) witness the signature of a birth mother or declarant father in accordance with
6170 Section 78B-15-302 if the signature occurs at the facility;

6171 (iii) enter the declarant father's information on the original birth certificate, but only if
6172 the mother and declarant father have signed a voluntary declaration of paternity or a court or
6173 administrative agency has issued an adjudication of paternity; and

6174 (iv) file the completed declaration with the original birth certificate.

6175 (b) If there is a presumed father, the voluntary declaration will only be valid if the
6176 presumed father also signs the voluntary declaration.

6177 (c) The state registrar shall file the information provided on the voluntary declaration
6178 of paternity form with the original birth certificate and may provide certified copies of the
6179 declaration of paternity as otherwise provided under Title 78B, Chapter 15, Utah Uniform
6180 Parentage Act.

6181 (6) (a) The state registrar shall publish a form for the voluntary declaration of paternity,
6182 a description of the process for filing a voluntary declaration of paternity, and of the rights and
6183 responsibilities established or effected by that filing, in accordance with Title 78B, Chapter 15,
6184 Utah Uniform Parentage Act.

6185 (b) Information regarding the form and services related to voluntary paternity
6186 establishment shall be made available to birthing facilities and to any other entity or individual
6187 upon request.

6188 (7) The name of a declarant father may only be included on the birth certificate of a
6189 child of unmarried parents if:

6190 (a) the mother and declarant father have signed a voluntary declaration of paternity; or

6191 (b) a court or administrative agency has issued an adjudication of paternity.

6192 (8) Voluntary declarations of paternity, adjudications of paternity by judicial or
6193 administrative agencies, and voluntary rescissions of paternity shall be filed with and
6194 maintained by the state registrar for the purpose of comparing information with the state case
6195 registry maintained by the Office of Recovery Services pursuant to Section [~~62A-11-104~~]
6196 26B-9-104.

6197 Section 180. Section **26B-8-105**, which is renumbered from Section 26-2-5.5 is
6198 renumbered and amended to read:

6199 [~~26-2-5.5~~]. **26B-8-105. Requirement to obtain parents' social security numbers.**

6200 (1) For each live birth that occurs in this state, the administrator of the birthing facility,
6201 as defined in Section [~~26-2-5~~] 26B-8-104, or other person responsible for completing and filing
6202 the birth certificate under Section [~~26-2-5~~] 26B-8-104 shall obtain the social security numbers
6203 of each parent and provide those numbers to the state registrar.

6204 (2) Each parent shall furnish his or her social security number to the person authorized
6205 to obtain the numbers under Subsection (1) unless a court or administrative agency has
6206 determined there is good cause for not furnishing a number under Subsection (1).

6207 (3) The state registrar shall, as soon as practicable, supply those social security
6208 numbers to the Office of Recovery Services within the [~~Department of Human Services~~]
6209 department.

6210 (4) The social security numbers obtained under this section may not be recorded on the
6211 child's birth certificate.

6212 (5) The state may not use any social security number obtained under this section for
6213 any reason other than enforcement of child support orders in accordance with the federal
6214 Family Support Act of 1988, [~~Public Law~~] Pub. L. No. 100-485.

6215 Section 181. Section **26B-8-106**, which is renumbered from Section 26-2-6 is
6216 renumbered and amended to read:

6217 ~~[26-2-6]~~. **26B-8-106. Foundling certificates.**

6218 (1) A foundling certificate shall be filed for each infant of unknown parentage found in
6219 the state. The certificate shall be prepared and filed with the local registrar of the district in
6220 which the infant was found by the person assuming custody.

6221 (2) The certificate shall be filed within 10 days after the infant is found and is
6222 acceptable for all purposes in lieu of a certificate of birth.

6223 Section 182. Section **26B-8-107**, which is renumbered from Section 26-2-7 is
6224 renumbered and amended to read:

6225 ~~[26-2-7]~~. **26B-8-107. Correction of errors or omissions in vital records --**
6226 **Conflicting birth and foundling certificates -- Rulemaking.**

6227 In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
6228 department may make rules:

- 6229 (1) governing applications to correct alleged errors or omissions on any vital record;
- 6230 (2) establishing procedures to resolve conflicting birth and foundling certificates; and
- 6231 (3) allowing for the correction and reissuance of a vital record that was originally
6232 created omitting a diacritical mark.

6233 Section 183. Section **26B-8-108**, which is renumbered from Section 26-2-8 is
6234 renumbered and amended to read:

6235 ~~[26-2-8]~~. **26B-8-108. Birth certificates -- Delayed registration.**

6236 (1) When a certificate of birth of a person born in this state has not been filed within
6237 the time provided in Subsection [~~26-2-5~~] 26B-8-104(2), a certificate of birth may be filed in
6238 accordance with department rules and subject to this section.

6239 (2) (a) The registrar shall mark a certificate of birth as "delayed" and show the date of
6240 registration if the certificate is registered one year or more after the date of birth.

6241 (b) The registrar shall abstract a summary statement of the evidence submitted in
6242 support of delayed registration onto the certificate.

6243 (3) When the minimum evidence required for delayed registration is not submitted or
6244 when the state registrar has reasonable cause to question the validity or adequacy of the
6245 evidence supporting the application, and the deficiencies are not corrected, the state registrar:

6246 (a) may not register the certificate; and

6247 (b) shall provide the applicant with a written statement indicating the reasons for denial
6248 of registration.

6249 (4) The state registrar has no duty to take further action regarding an application which
6250 is not actively pursued.

6251 Section 184. Section **26B-8-109**, which is renumbered from Section 26-2-9 is
6252 renumbered and amended to read:

6253 ~~[26-2-9]~~. **26B-8-109. Birth certificates -- Petition for issuance of delayed**
6254 **certificate -- Court procedure.**

6255 (1) (a) If registration of a certificate of birth under Section ~~[26-2-8]~~ 26B-8-108 is
6256 denied, the person seeking registration may bring an action by a verified petition in the Utah
6257 ~~[district]~~ court encompassing where the petitioner resides or in the district encompassing Salt
6258 Lake City.

6259 (b) The petition shall request an order establishing a record of the date and place of the
6260 birth and the parentage of the person whose birth is to be registered.

6261 (2) The petition shall be on a form furnished by the state registrar and shall allege:

6262 (a) the person for whom registration of a delayed certificate is sought was born in this
6263 state and is still living;

6264 (b) no registered certificate of birth of the person can be found in the state office of
6265 vital statistics or the office of any local registrar;

6266 (c) diligent efforts by the petitioner have failed to obtain the evidence required by
6267 department rule; and

6268 (d) the state registrar has denied the petitioner's request to register a delayed certificate
6269 of birth.

6270 (3) The petition shall be accompanied by a written statement of the state registrar
6271 indicating the reasons for denial of registration and all documentary evidence which was
6272 submitted in support of registration.

6273 (4) The court shall fix a time and place for hearing the petition and shall give the state
6274 registrar 15 [~~days~~] days' notice of the hearing. The state registrar or his authorized
6275 representative may appear and testify at the hearing.

6276 (5) (a) If the court finds the person for whom registration of a certificate of birth is
6277 sought under Section [~~26-2-8~~] 26B-8-108 was born in this state, it shall make findings as to the
6278 place and date of birth, parentage, and other findings as may be required and shall issue an
6279 order, on a form prescribed and furnished by the state registrar, to establish a court-ordered
6280 delayed certificate of birth.

6281 (b) The order shall include the birth data to be registered, a description of the evidence
6282 presented, and the date of the court's action.

6283 [~~(b)~~] (c) The clerk of the court shall forward each order to the state registrar not later
6284 than the tenth day of the calendar month following the month in which the order was entered.

6285 (d) The order described in Subsection (5)(a) shall be registered by the state registrar
6286 and constitutes the certificate of birth.

6287 Section 185. Section **26B-8-110**, which is renumbered from Section 26-2-10 is
6288 renumbered and amended to read:

6289 [~~26-2-10~~]. **26B-8-110. Supplementary certificate of birth.**

6290 (1) An individual born in this state may request the state registrar to register a
6291 supplementary birth certificate for the individual if:

6292 (a) the individual is legally recognized as a child of the individual's natural parents

6293 when the individual's natural parents are subsequently married;

6294 (b) the individual's parentage has been determined by a state court of the United States
6295 or a Canadian provincial court with jurisdiction; or

6296 (c) the individual has been legally adopted, as a child or as an adult, under the law of
6297 this state, any other state, or any province of Canada.

6298 (2) The application for registration of a supplementary birth certificate may be made
6299 by:

6300 (a) the individual requesting registration under Subsection (1) if the individual is of
6301 legal age;

6302 (b) a legal representative; or

6303 (c) any agency authorized to receive children for placement or adoption under the laws
6304 of this or any other state.

6305 (3) (a) The state registrar shall require that an applicant submit identification and proof
6306 according to department rules.

6307 (b) In the case of an adopted individual, that proof may be established by order of the
6308 court in which the adoption proceedings were held.

6309 (4) (a) After the supplementary birth certificate is registered, any information disclosed
6310 from the record shall be from the supplementary birth certificate.

6311 (b) Access to the original birth certificate and to the evidence submitted in support of
6312 the supplementary birth certificate are not open to inspection except upon the order of a Utah
6313 district court or as described in Section [78B-6-141](#) or Section [78B-6-144](#).

6314 Section 186. Section **26B-8-111**, which is renumbered from Section 26-2-11 is
6315 renumbered and amended to read:

6316 ~~[26-2-11]~~. **26B-8-111**. **Name or sex change -- Registration of court order and**
6317 **amendment of birth certificate.**

6318 (1) When a person born in this state has a name change or sex change approved by an
6319 order of a Utah ~~[district]~~ court or a court of competent jurisdiction of another state or a

6320 province of Canada, a certified copy of the order may be filed with the state registrar with an
6321 application form provided by the registrar.

6322 (2) (a) Upon receipt of the application, a certified copy of the order, and payment of the
6323 required fee, the state registrar shall review the application, and if complete, register it and note
6324 the fact of the amendment on the otherwise unaltered original certificate.

6325 (b) The amendment shall be registered with and become a part of the original
6326 certificate and a certified copy shall be issued to the applicant without additional cost.

6327 Section 187. Section **26B-8-112**, which is renumbered from Section 26-2-12.5 is
6328 renumbered and amended to read:

6329 ~~[26-2-12.5]~~. **26B-8-112. Certified copies of birth certificates -- Fees credited to**
6330 **Children's Account.**

6331 (1) In addition to the fees provided for in Section [26B-1-209](#), the department and local
6332 registrars authorized to issue certified copies shall charge an additional \$3 fee for each certified
6333 copy of a birth certificate, including certified copies of supplementary and amended birth
6334 certificates, under Sections ~~[26-2-8 through 26-2-11]~~ [26B-8-108](#) through [26B-8-111](#). ~~[This]~~

6335 (2) The additional fee described in Subsection (1) may be charged only for the first
6336 copy requested at any one time.

6337 ~~[(2)]~~ (3) The fee shall be transmitted monthly to the state treasurer and credited to the
6338 Children's Account ~~[established]~~ created in Section [80-2-501](#).

6339 Section 188. Section **26B-8-113**, which is renumbered from Section 26-2-12.6 is
6340 renumbered and amended to read:

6341 ~~[26-2-12.6]~~. **26B-8-113. Fee waived for certified copy of birth certificate.**

6342 (1) Notwithstanding ~~[Section]~~ Sections [26B-1-209](#) and ~~[Section 26-2-12.5]~~ [26B-6-112](#),
6343 the department shall waive a fee that would otherwise be charged for a certified copy of a birth
6344 certificate, if the individual whose birth is confirmed by the birth certificate is:

6345 (a) the individual requesting the certified copy of the birth certificate; and

6346 (b) (i) homeless, as defined in Section ~~[26-18-411]~~ [26B-3-207](#);

- 6347 (ii) a person who is homeless, as defined in Section 35A-5-302;
- 6348 (iii) an individual whose primary nighttime residence is a location that is not designed
- 6349 for or ordinarily used as a sleeping accommodation for an individual;
- 6350 (iv) a homeless service provider as verified by the Department of Workforce Services;
- 6351 or
- 6352 (v) a homeless child or youth, as defined in 42 U.S.C. Sec. 11434a.
- 6353 (2) To satisfy the requirement in Subsection (1)(b), the department shall accept written
- 6354 verification that the individual is homeless or a person, child, or youth who is homeless from:
- 6355 (a) a homeless shelter;
- 6356 (b) a permanent housing, permanent, supportive, or transitional facility, as defined in
- 6357 Section 35A-5-302;
- 6358 (c) the Department of Workforce Services;
- 6359 (d) a homeless service provider as verified by the Department of Workforce Services;
- 6360 or
- 6361 (e) a local educational agency liaison for homeless children and youth designated under
- 6362 42 U.S.C. Sec. 11432(g)(1)(J)(ii).
- 6363 Section 189. Section 26B-8-114, which is renumbered from Section 26-2-13 is
- 6364 renumbered and amended to read:
- 6365 **[26-2-13]. 26B-8-114. Certificate of death -- Execution and registration**
- 6366 **requirements -- Information provided to lieutenant governor.**
- 6367 (1) (a) A certificate of death for each death that occurs in this state shall be filed with
- 6368 the local registrar of the district in which the death occurs, or as otherwise directed by the state
- 6369 registrar, within five days after death and prior to the decedent's interment, any other disposal,
- 6370 or removal from the registration district where the death occurred.
- 6371 (b) A certificate of death shall be registered if the certificate of death is completed and
- 6372 filed in accordance with this ~~chapter~~ part.
- 6373 (2) (a) If the place of death is unknown but the dead body is found in this state:

6374 (i) the certificate of death shall be completed and filed in accordance with this section;
6375 and

6376 (ii) the place where the dead body is found shall be shown as the place of death.

6377 (b) If the date of death is unknown, the date shall be determined by approximation.

6378 (3) (a) When death occurs in a moving conveyance in the United States and the
6379 decedent is first removed from the conveyance in this state:

6380 (i) the certificate of death shall be filed with:

6381 (A) the local registrar of the district where the decedent is removed; or

6382 (B) a person designated by the state registrar; and

6383 (ii) the place where the decedent is removed shall be considered the place of death.

6384 (b) When a death occurs on a moving conveyance outside the United States and the
6385 decedent is first removed from the conveyance in this state:

6386 (i) the certificate of death shall be filed with:

6387 (A) the local registrar of the district where the decedent is removed; or

6388 (B) a person designated by the state registrar; and

6389 (ii) the certificate of death shall show the actual place of death to the extent it can be
6390 determined.

6391 (4) (a) Subject to Subsections (4)(d) and (10), a custodial funeral service director or, if a
6392 funeral service director is not retained, a dispositioner shall sign the certificate of death.

6393 (b) The custodial funeral service director, an agent of the custodial funeral service
6394 director, or, if a funeral service director is not retained, a dispositioner shall:

6395 (i) file the certificate of death prior to any disposition of a dead body or fetus; and

6396 (ii) obtain the decedent's personal data from the next of kin or the best qualified person
6397 or source available, including the decedent's social security number, if known.

6398 (c) The certificate of death may not include the decedent's social security number.

6399 (d) A dispositioner may not sign a certificate of death, unless the signature is witnessed
6400 by the state registrar or a local registrar.

6401 (5) (a) Except as provided in Section [~~26-2-14~~] 26B-8-115, fetal death certificates, the
6402 medical section of the certificate of death shall be completed, signed, and returned to the
6403 funeral service director, or, if a funeral service director is not retained, a dispositioner, within
6404 72 hours after death by the health care professional who was in charge of the decedent's care
6405 for the illness or condition which resulted in death, except when inquiry is required by [~~Title~~
6406 ~~26, Chapter 4, Utah Medical Examiner Act~~] Part 2, Utah Medical Examiner.

6407 (b) In the absence of the health care professional or with the health care professional's
6408 approval, the certificate of death may be completed and signed by an associate physician, the
6409 chief medical officer of the institution in which death occurred, or a physician who performed
6410 an autopsy upon the decedent, if:

- 6411 (i) the person has access to the medical history of the case;
- 6412 (ii) the person views the decedent at or after death; and
- 6413 (iii) the death is not due to causes required to be investigated by the medical examiner.

6414 (6) When death occurs more than 365 days after the day on which the decedent was last
6415 treated by a health care professional, the case shall be referred to the medical examiner for
6416 investigation to determine and certify the cause, date, and place of death.

6417 (7) When inquiry is required by [~~Title 26, Chapter 4, Utah Medical Examiner Act~~] Part
6418 2, Utah Medical Examiner, the medical examiner shall make an investigation and complete and
6419 sign the medical section of the certificate of death within 72 hours after taking charge of the
6420 case.

6421 (8) If the cause of death cannot be determined within 72 hours after death:

6422 (a) the medical section of the certificate of death shall be completed as provided by
6423 department rule;

6424 (b) the attending health care professional or medical examiner shall give the funeral
6425 service director, or, if a funeral service director is not retained, a dispositioner, notice of the
6426 reason for the delay; and

6427 (c) final disposition of the decedent may not be made until authorized by the attending

6428 health care professional or medical examiner.

6429 (9) (a) When a death is presumed to have occurred within this state but the dead body
6430 cannot be located, a certificate of death may be prepared by the state registrar upon receipt of
6431 an order of a Utah [~~district~~] court.

6432 (b) The order described in Subsection (9)(a) shall include a finding of fact stating the
6433 name of the decedent, the date of death, and the place of death.

6434 (c) A certificate of death prepared under Subsection (9)(a) shall:

6435 (i) show the date of registration; and

6436 (ii) identify the court and the date of the order.

6437 (10) It is unlawful for a dispositioner to charge for or accept any remuneration for:

6438 (a) signing a certificate of death; or

6439 (b) performing any other duty of a dispositioner, as described in this section.

6440 (11) The state registrar shall, within five business days after the day on which the state
6441 registrar or local registrar registers a certificate of death for a Utah resident, inform the
6442 lieutenant governor of:

6443 (a) the decedent's name, last known residential address, date of birth, and date of death;
6444 and

6445 (b) any other information requested by the lieutenant governor to assist the county
6446 clerk in identifying the decedent for the purpose of removing the decedent from the official
6447 register of voters.

6448 (12) The lieutenant governor shall, within one business day after the day on which the
6449 lieutenant governor receives the information described in Subsection (11), provide the
6450 information to the county clerks.

6451 Section 190. Section **26B-8-115**, which is renumbered from Section 26-2-14 is
6452 renumbered and amended to read:

6453 ~~[26-2-14]~~. **26B-8-115. Fetal death certificate -- Filing and registration**
6454 **requirements.**

6455 (1) A fetal death certificate shall be filed for each fetal death which occurs in this state.
6456 The certificate shall be filed within five days after delivery with the local registrar or as
6457 otherwise directed by the state registrar. The certificate shall be registered if it is completed and
6458 filed in accordance with this ~~[chapter]~~ part.

6459 (2) When a dead fetus is delivered in an institution, the institution administrator or his
6460 designated representative shall prepare and file the fetal death certificate. The attending
6461 physician shall state in the certificate the cause of death and sign the certificate.

6462 (3) When a dead fetus is delivered outside an institution, the physician in attendance at
6463 or immediately after delivery shall complete, sign, and file the fetal death certificate.

6464 (4) When a fetal death occurs without medical attendance at or immediately after the
6465 delivery or when inquiry is required by ~~[Title 26, Chapter 4, Utah Medical Examiner Act]~~ Part
6466 2, Utah Medical Examiner, the medical examiner shall investigate the cause of death and
6467 prepare and file the certificate of fetal death within five days after taking charge of the case.

6468 (5) When a fetal death occurs in a moving conveyance and the dead fetus is first
6469 removed from the conveyance in this state or when a dead fetus is found in this state and the
6470 place of death is unknown, the death shall be registered in this state. The place where the dead
6471 fetus was first removed from the conveyance or found shall be considered the place of death.

6472 (6) Final disposition of the dead fetus may not be made until the fetal death certificate
6473 has been registered.

6474 Section 191. Section **26B-8-116**, which is renumbered from Section 26-2-14.1 is
6475 renumbered and amended to read:

6476 ~~[26-2-14.1]~~. **26B-8-116. Certificate of birth resulting in stillbirth.**

6477 (1) ~~[For purposes of this section and Section 26-2-14.2]~~ As used in this section,
6478 "stillbirth" and "stillborn child" ~~[shall have the same meaning]~~ mean the same as "dead fetus"
6479 as defined in Section [26-2-2] 26B-8-101.

6480 (2) (a) In addition to the requirements of Section ~~[26-2-14]~~ 26B-8-115, the state
6481 registrar shall establish a certificate of birth resulting in stillbirth on a form approved by the

6482 state registrar for each stillbirth occurring in this state.

6483 (b) This certificate shall be offered to the parent or parents of a stillborn child.

6484 (3) The certificate of birth resulting in stillbirth shall meet all of the format and filing
6485 requirements of Sections [~~26-2-4 and 26-2-5~~] 26B-8-103 and 26B-8-104, relating to a live
6486 birth.

6487 (4) The person who prepares a certificate pursuant to this section shall leave blank any
6488 references to the stillborn child's name if the stillborn child's parent or parents do not wish to
6489 provide a name for the stillborn child.

6490 (5) Notwithstanding Subsections (2) and (3), the certificate of birth resulting in
6491 stillbirth shall be filed with the designated registrar within 10 days following the delivery and
6492 prior to cremation or removal of the fetus from the registration district.

6493 Section 192. Section **26B-8-117**, which is renumbered from Section 26-2-14.2 is
6494 renumbered and amended to read:

6495 ~~[26-2-14.2]~~. **26B-8-117**. **Delayed registration of birth resulting in stillbirth.**

6496 When a birth resulting in stillbirth occurring in this state has not been registered within
6497 one year after the date of delivery, a certificate marked "delayed" may be filed and registered in
6498 accordance with department rule relating to evidentiary and other requirements sufficient to
6499 substantiate the alleged facts of birth resulting in stillbirth.

6500 Section 193. Section **26B-8-118**, which is renumbered from Section 26-2-14.3 is
6501 renumbered and amended to read:

6502 ~~[26-2-14.3]~~. **26B-8-118**. **Certificate of early term stillbirth.**

6503 (1) As used in this section, "early term stillborn child" means a product of human
6504 conception, other than in the circumstances described in Subsection 76-7-301(1), that:

6505 (a) is of at least 16 weeks' gestation but less than 20 weeks' gestation, calculated from
6506 the day on which the mother's last normal menstrual period began to the day of delivery; and

6507 (b) is not born alive.

6508 (2) The state registrar shall issue a certificate of early term stillbirth to a parent of an

6509 early term stillborn child if:

6510 (a) the parent requests, on a form created by the state registrar, that the state registrar
6511 register and issue a certificate of early term stillbirth for the early term stillborn child; and

6512 (b) the parent files with the state registrar:

6513 (i) (A) a signed statement from a physician confirming the delivery of the early term
6514 stillborn child; or

6515 (B) an accurate copy of the parent's medical records related to the early term stillborn
6516 child; and

6517 (ii) any other record the state registrar determines, by rule made in accordance with
6518 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, is necessary for accurate
6519 recordkeeping.

6520 (3) The certificate of early term stillbirth described in Subsection (2) shall meet all of
6521 the format and filing requirements of Section ~~[26-2-4]~~ [26B-8-103](#).

6522 (4) A person who prepares a certificate of early term stillbirth under this section shall
6523 leave blank any references to an early term stillborn child's name if the early term stillborn
6524 child's parent does not wish to provide a name for the early term stillborn child.

6525 Section 194. Section **26B-8-119**, which is renumbered from Section 26-2-15 is
6526 renumbered and amended to read:

6527 ~~[26-2-15]~~. **26B-8-119. Petition for establishment of unregistered birth or death**
6528 **-- Court procedure.**

6529 (1) A person holding a direct, tangible, and legitimate interest as described in
6530 Subsection ~~[26-2-22]~~ [26B-8-125](#)(3)(a) or (b) may petition for a court order establishing the
6531 fact, time, and place of a birth or death that is not registered or for which a certified copy of the
6532 registered birth or death certificate is not obtainable. The person shall verify the petition and
6533 file the petition in the Utah ~~[district]~~ court for the county where:

6534 (a) the birth or death is alleged to have occurred;

6535 (b) the person resides whose birth is to be established; or

6536 (c) the decedent named in the petition resided at the date of death.
6537 (2) In order for the court to have jurisdiction, the petition shall:
6538 (a) allege the date, time, and place of the birth or death; and
6539 (b) state either that no certificate of birth or death has been registered or that a copy of
6540 the registered certificate cannot be obtained.

6541 (3) The court shall set a hearing for five to 10 days after the day on which the petition
6542 is filed.

6543 (4) (a) If the time and place of birth or death are in question, the court shall hear
6544 available evidence and determine the time and place of the birth or death.

6545 (b) If the time and place of birth or death are not in question, the court shall determine
6546 the time and place of birth or death to be those alleged in the petition.

6547 (5) A court order under this section shall be made on a form prescribed and furnished
6548 by the department and is effective upon the filing of a certified copy of the order with the state
6549 registrar.

6550 (6) (a) For purposes of this section, the birth certificate of an adopted alien child, as
6551 defined in Section [78B-6-108](#), is considered to be unobtainable if the child was born in a
6552 country that is not recognized by department rule as having an established vital records
6553 registration system.

6554 (b) If the adopted child was born in a country recognized by department rule, but a
6555 person described in Subsection (1) is unable to obtain a certified copy of the birth certificate,
6556 the state registrar shall authorize the preparation of a birth certificate if the state registrar
6557 receives a written statement signed by the registrar of the child's birth country stating a certified
6558 copy of the birth certificate is not available.

6559 Section 195. Section **26B-8-120**, which is renumbered from Section 26-2-16 is
6560 renumbered and amended to read:

6561 ~~[26-2-16]~~. **26B-8-120**. **Certificate of death -- Duties of a custodial funeral**
6562 **service director, an agent of a funeral service director, or a dispositioner -- Medical**

6563 **certification -- Records of funeral service director or dispositioner -- Information filed**
6564 **with local registrar -- Unlawful signing of certificate of death.**

6565 (1) The custodial funeral service director or, if a funeral service director is not retained,
6566 a dispositioner shall sign the certificate of death prior to any disposition of a dead body or dead
6567 fetus.

6568 (2) The custodial funeral service director, an agent of the custodial funeral service
6569 director, or, if a funeral service director is not retained, a dispositioner shall:

6570 (a) obtain personal and statistical information regarding the decedent from the
6571 available persons best qualified to provide the information;

6572 (b) present the certificate of death to the attending health care professional, if any, or to
6573 the medical examiner who shall certify the cause of death and other information required on the
6574 certificate of death;

6575 (c) provide the address of the custodial funeral service director or, if a funeral service
6576 director is not retained, a dispositioner;

6577 (d) certify the date and place of burial; and

6578 (e) file the certificate of death with the state or local registrar.

6579 (3) A funeral service director, dispositioner, embalmer, or other person who removes a
6580 dead body or dead fetus from the place of death or transports or is in charge of final disposal of
6581 a dead body or dead fetus, shall keep a record identifying the dead body or dead fetus, and
6582 containing information pertaining to receipt, removal, and delivery of the dead body or dead
6583 fetus as prescribed by department rule.

6584 (4) (a) Not later than the tenth day of each month, every licensed funeral service
6585 establishment shall send to the local registrar and the department a list of the information
6586 required in Subsection (3) for each casket furnished and for funerals performed when no casket
6587 was furnished, during the preceding month.

6588 (b) The list described in Subsection (4)(a) shall be in the form prescribed by the state
6589 registrar.

6590 (5) Any person who intentionally signs the portion of a certificate of death that is
6591 required to be signed by a funeral service director or a dispositioner under Subsection (1) is
6592 guilty of a class B misdemeanor, unless the person:

- 6593 (a) (i) is a funeral service director; and
6594 (ii) is employed by a licensed funeral establishment; or
6595 (b) is a dispositioner, if a funeral service director is not retained.

6596 (6) The state registrar shall post information on the state registrar's website, providing
6597 instructions to a dispositioner for complying with the requirements of law relating to the
6598 dispositioner's responsibilities for:

- 6599 (a) completing and filing a certificate of death; and
6600 (b) possessing, transporting, and disposing of a dead body or dead fetus.

6601 (7) The provisions of this [~~chapter~~] part shall be construed to avoid interference, to the
6602 fullest extent possible, with the ceremonies, customs, rites, or beliefs of the decedent and the
6603 decedent's next of kin for disposing of a dead body or dead fetus.

6604 Section 196. Section **26B-8-121**, which is renumbered from Section 26-2-17 is
6605 renumbered and amended to read:

6606 **[~~26-2-17~~]. 26B-8-121. Certificate of death -- Registration prerequisite to**
6607 **interment -- Burial-transit permits -- Procedure where body donated under anatomical**
6608 **gift law -- Permit for disinterment.**

6609 (1) (a) A dead body or dead fetus may not be interred or otherwise disposed of or
6610 removed from the registration district in which death or fetal death occurred or the remains are
6611 found until a certificate of death is registered.

6612 (b) Subsection (1)(a) does not apply to fetal remains for a fetus that is less than 20
6613 weeks in gestational age.

6614 (2) (a) For deaths or fetal deaths which occur in this state, no burial-transit permit is
6615 required for final disposition of the remains if:

- 6616 (i) disposition occurs in the state and is performed by a funeral service director; or

- 6617 (ii) the disposition takes place with authorization of the next of kin and in:
- 6618 (A) a general acute hospital as [~~that term is~~] defined in Section [~~26-21-2~~] [26B-2-201](#),
- 6619 that is licensed by the department; or
- 6620 (B) in a pathology laboratory operated under contract with a general acute hospital
- 6621 licensed by the department.
- 6622 (b) For an abortion or miscarriage that occurs at a health care facility, no burial-transit
- 6623 permit is required for final disposition of the fetal remains if:
- 6624 (i) disposition occurs in the state and is performed by a funeral service director; or
- 6625 (ii) the disposition takes place:
- 6626 (A) with authorization of the parent of a miscarried fetus or the pregnant woman for an
- 6627 aborted fetus; and
- 6628 (B) in a general acute hospital as [~~that term is~~] defined in Section [~~26-21-2~~] [26B-2-201](#),
- 6629 or a pathology laboratory operated under contract with a general acute hospital.
- 6630 (3) (a) A burial-transit permit shall be issued by the local registrar of the district where
- 6631 the certificate of death or fetal death is registered:
- 6632 (i) for a dead body or a dead fetus to be transported out of the state for final
- 6633 disposition; or
- 6634 (ii) when disposition of the dead body or dead fetus is made by a person other than a
- 6635 funeral service director.
- 6636 (b) For fetal remains that are less than 20 weeks in gestational age, a burial-transit
- 6637 permit shall be issued by the local registrar of the district where the health care facility that is in
- 6638 possession of the fetal remains is located:
- 6639 (i) for the fetal remains to be transported out of the state for final disposition; or
- 6640 (ii) when disposition of the fetal remains is made by a person other than a funeral
- 6641 service director.
- 6642 (c) A local registrar issuing a burial-transit permit issued under Subsection (3)(b):
- 6643 (i) may not require an individual to designate a name for the fetal remains; and

6644 (ii) may leave the space for a name on the burial-transit permit blank; and
6645 (d) shall redact from any public records maintained under this [chapter] part any
6646 information:

- 6647 (i) that is submitted under Subsection (3)(c); and
- 6648 (ii) that may be used to identify the parent or pregnant woman.

6649 (4) A burial-transit permit issued under the law of another state which accompanies a
6650 dead body, dead fetus, or fetal remains brought into this state is authority for final disposition
6651 of the dead body, dead fetus, or fetal remains in this state.

6652 (5) When a dead body or dead fetus or any part of the dead body or dead fetus has been
6653 donated under [the] Part 3, Revised Uniform Anatomical Gift Act, or similar laws of another
6654 state and the preservation of the gift requires the immediate transportation of the dead body,
6655 dead fetus, or any part of the body or fetus outside of the registration district in which death
6656 occurs or the remains are found, or into this state from another state, the dead body or dead
6657 fetus or any part of the body or fetus may be transported and the burial-transit permit required
6658 by this section obtained within a reasonable time after transportation.

6659 (6) A permit for disinterment and reinterment is required prior to disinterment of a
6660 dead body, dead fetus, or fetal remains, except as otherwise provided by statute or department
6661 rule.

6662 Section 197. Section **26B-8-122**, which is renumbered from Section 26-2-18 is
6663 renumbered and amended to read:

6664 ~~[26-2-18]~~. **26B-8-122. Interments -- Duties of sexton or person in charge --**
6665 **Record of interments -- Information filed with local registrar.**

6666 (1) (a) A sexton or person in charge of any premises in which interments are made may
6667 not inter or permit the interment of any dead body, dead fetus, or fetal remains unless the
6668 interment is made by a funeral service director or by a person holding a burial-transit permit.

6669 (b) The right and duty to control the disposition of a deceased person shall be governed
6670 by Sections [58-9-601](#) through [58-9-604](#).

6671 (2) (a) The sexton or the person in charge of any premises where interments are made
6672 shall keep a record of all interments made in the premises under their charge, stating the name
6673 of the decedent, place of death, date of burial, and name and address of the funeral service
6674 director or other person making the interment.

6675 (b) The record described in this Subsection (2) shall be open to public inspection.

6676 (c) A city or county clerk may, at the clerk's option, maintain the interment records
6677 described in this Subsection (2) on behalf of the sexton or person in charge of any premises in
6678 which interments are made.

6679 (3) (a) Not later than the tenth day of each month, the sexton, person in charge of the
6680 premises, or city or county clerk who maintains the interment records shall send to the local
6681 registrar and the department a list of all interments made in the premises during the preceding
6682 month.

6683 (b) The list described in Subsection (3)(a) shall be in the form prescribed by the state
6684 registrar.

6685 Section 198. Section **26B-8-123**, which is renumbered from Section 26-2-19 is
6686 renumbered and amended to read:

6687 ~~[26-2-19]~~. **26B-8-123**. **Rules of department for transmittal of certificates and**
6688 **keeping of records by local registrar.**

6689 Each local registrar shall transmit all records registered by him to the department in
6690 accordance with department rules. The manner of keeping local copies of vital records and the
6691 uses of them shall be prescribed by department rules.

6692 Section 199. Section **26B-8-124**, which is renumbered from Section 26-2-21 is
6693 renumbered and amended to read:

6694 ~~[26-2-21]~~. **26B-8-124**. **Local registrars authorized to issue certified copies of**
6695 **records.**

6696 The state registrar may authorize local registrars to issue certified copies of vital
6697 records.

6698 Section 200. Section **26B-8-125**, which is renumbered from Section 26-2-22 is
6699 renumbered and amended to read:

6700 ~~[26-2-22]~~. **26B-8-125. Inspection of vital records.**

6701 (1) As used in this section:

6702 (a) "Designated legal representative" means an attorney, physician, funeral service
6703 director, genealogist, or other agent of the subject, or an immediate family member of the
6704 subject, who has been delegated the authority to access vital records.

6705 (b) "Drug use intervention or suicide prevention effort" means a program that studies
6706 or promotes the prevention of drug overdose deaths or suicides in the state.

6707 (c) "Immediate family member" means a spouse, child, parent, sibling, grandparent, or
6708 grandchild.

6709 (2) (a) The vital records shall be open to inspection, but only in compliance with the
6710 provisions of this [chapter] part, department rules, and Sections [78B-6-141](#) and [78B-6-144](#).

6711 (b) It is unlawful for any state or local officer or employee to disclose data contained in
6712 vital records contrary to this [chapter] part, department rule, Section [78B-6-141](#), or Section
6713 [78B-6-144](#).

6714 (c) (i) An adoption document is open to inspection as provided in Section [78B-6-141](#)
6715 or Section [78B-6-144](#).

6716 (ii) A birth parent may not access an adoption document under Subsection
6717 [78B-6-141](#)(3).

6718 (d) A custodian of vital records may permit inspection of a vital record or issue a
6719 certified copy of a record or a part of a record when the custodian is satisfied that the applicant
6720 has demonstrated a direct, tangible, and legitimate interest.

6721 (3) Except as provided in Subsection (4), a direct, tangible, and legitimate interest in a
6722 vital record is present only if:

6723 (a) the request is from:

6724 (i) the subject;

- 6725 (ii) an immediate family member of the subject;
- 6726 (iii) the guardian of the subject;
- 6727 (iv) a designated legal representative of the subject; or
- 6728 (v) a person, including a child-placing agency as defined in Section [78B-6-103](#), with
- 6729 whom a child has been placed pending finalization of an adoption of the child;
- 6730 (b) the request involves a personal or property right of the subject of the record;
- 6731 (c) the request is for official purposes of a public health authority or a state, local, or
- 6732 federal governmental agency;
- 6733 (d) the request is for a drug use intervention or suicide prevention effort or a statistical
- 6734 or medical research program and prior consent has been obtained from the state registrar; or
- 6735 (e) the request is a certified copy of an order of a court of record specifying the record
- 6736 to be examined or copied.
- 6737 (4) (a) Except as provided in Title 78B, Chapter 6, Part 1, Utah Adoption Act, a parent,
- 6738 or an immediate family member of a parent, who does not have legal or physical custody of or
- 6739 visitation or parent-time rights for a child because of the termination of parental rights under
- 6740 Title 80, Chapter 4, Termination and Restoration of Parental Rights, or by virtue of consenting
- 6741 to or relinquishing a child for adoption pursuant to Title 78B, Chapter 6, Part 1, Utah Adoption
- 6742 Act, may not be considered as having a direct, tangible, and legitimate interest under this
- 6743 section.
- 6744 (b) Except as provided in Subsection (2)(d), a commercial firm or agency requesting
- 6745 names, addresses, or similar information may not be considered as having a direct, tangible,
- 6746 and legitimate interest under this section.
- 6747 (5) Upon payment of a fee established in accordance with Section [63J-1-504](#), the office
- 6748 shall make the following records available to the public:
- 6749 (a) except as provided in Subsection [~~26-2-10~~] [26B-8-110](#)(4)(b), a birth record,
- 6750 excluding confidential information collected for medical and health use, if 100 years or more
- 6751 have passed since the date of birth;

6752 (b) a death record if 50 years or more have passed since the date of death; and
6753 (c) a vital record not subject to Subsection (5)(a) or (b) if 75 years or more have passed
6754 since the date of the event upon which the record is based.

6755 (6) Upon payment of a fee established in accordance with Section 63J-1-504, the office
6756 shall make an adoption document available as provided in Sections 78B-6-141 and 78B-6-144.

6757 (7) The office shall make rules in accordance with Title 63G, Chapter 3, Utah
6758 Administrative Rulemaking Act, establishing procedures and the content of forms as follows:

- 6759 (a) for the inspection of adoption documents under Subsection 78B-6-141(4);
- 6760 (b) for a birth parent's election to permit identifying information about the birth parent
6761 to be made available, under Section 78B-6-141;
- 6762 (c) for the release of information by the mutual-consent, voluntary adoption registry,
6763 under Section 78B-6-144;
- 6764 (d) for collecting fees and donations under Section 78B-6-144.5; and
- 6765 (e) for the review and approval of a request described in Subsection (3)(d).

6766 Section 201. Section 26B-8-126, which is renumbered from Section 26-2-23 is
6767 renumbered and amended to read:

6768 **[26-2-23]. 26B-8-126. Records required to be kept by health care institutions**
6769 **-- Information filed with local registrar and department.**

6770 (1) (a) All administrators or other persons in charge of hospitals, nursing homes, or
6771 other institutions, public or private, to which persons resort for treatment of diseases,
6772 confinements, or are committed by law, shall record all the personal and statistical information
6773 about patients of their institutions as required in certificates prescribed by this ~~chapter~~ part.

- 6774 (b) The information described in Subsection (1)(a) shall:
 - 6775 (i) be recorded for collection at the time of admission of a patient;
 - 6776 (ii) be obtained from the patient, if possible; and
 - 6777 (iii) if the information cannot be obtained from the patient, the information shall be
6778 secured in as complete a manner as possible from other persons acquainted with the facts.

6779 (2) (a) When a dead body or dead fetus is released or disposed of by an institution, the
6780 person in charge of the institution shall keep a record showing:

6781 (i) the name of the deceased;

6782 (ii) the date of death of the deceased;

6783 (iii) the name and address of the person to whom the dead body or dead fetus is
6784 released; and

6785 (iv) the date that the dead body or dead fetus is removed from the institution.

6786 (b) If final disposal is by the institution, the date, place, manner of disposition, and the
6787 name of the person authorizing disposition shall be recorded by the person in charge of the
6788 institution.

6789 (3) Not later than the tenth day of each month, the administrator of each institution
6790 shall cause to be sent to the local registrar and the department a list of all births, deaths, fetal
6791 deaths, and induced abortions occurring in the institution during the preceding month. The list
6792 shall be in the form prescribed by the state registrar.

6793 (4) A person or institution who, in good faith, releases a dead body or dead fetus, under
6794 this section, to a funeral service director or a dispositioner is immune from civil liability
6795 connected, directly or indirectly, with release of the dead body or dead fetus.

6796 Section 202. Section **26B-8-127**, which is renumbered from Section 26-2-24 is
6797 renumbered and amended to read:

6798 ~~[26-2-24]~~. **26B-8-127. Marriage licenses -- Execution and filing requirements.**

6799 (1) The state registrar shall supply county clerks with application forms for marriage
6800 licenses.

6801 (2) Completed applications shall be transmitted by the clerks to the state registrar
6802 monthly.

6803 (3) The personal identification information contained on each application for a
6804 marriage license filed with the county clerk shall be entered on a form supplied by the state
6805 registrar.

6806 (4) The person performing the marriage shall furnish the date and place of marriage
6807 and his name and address.

6808 (5) The form described in Subsection (1) shall be completed and certified by the county
6809 clerk before it is filed with the state registrar.

6810 Section 203. Section **26B-8-128**, which is renumbered from Section 26-2-25 is
6811 renumbered and amended to read:

6812 ~~[26-2-25].~~ **26B-8-128. Divorce or adoption -- Duty of court clerk to file**
6813 **certificates or reports.**

6814 (1) For each adoption, annulment of adoption, divorce, and annulment of marriage
6815 ordered or decreed in this state, the clerk of the court shall prepare a divorce certificate or
6816 report of adoption on a form furnished by the state registrar.

6817 (2) The petitioner shall provide the information necessary to prepare the certificate or
6818 report under Subsection (1).

6819 (3) The clerk shall:

6820 (a) prepare the certificate or report under Subsection (1); and

6821 (b) complete the remaining entries for the certificate or report immediately after the
6822 decree or order becomes final.

6823 (4) On or before the 15th day of each month, the clerk shall forward the divorce
6824 certificates and reports of adoption under Subsection (1) completed by the clerk during the
6825 preceding month to the state registrar.

6826 (5) (a) A report of adoption under Subsection (1) may be provided to the attorney who
6827 is providing representation of a party to the adoption or the child-placing agency, as defined in
6828 Section **78B-6-103**, that is placing the child.

6829 (b) If a report of adoption is provided to the attorney or the child-placing agency, as
6830 defined in Section **78B-6-103**, the attorney or the child-placing agency shall immediately
6831 provide the report of adoption to the state registrar.

6832 Section 204. Section **26B-8-129**, which is renumbered from Section 26-2-26 is

6833 renumbered and amended to read:

6834 ~~[26-2-26]~~. **26B-8-129**. **Certified copies of vital records -- Preparation by state**
6835 **and local registrars -- Evidentiary value.**

6836 (1) The state registrar and local registrars authorized by the department under Section
6837 ~~[26-2-21]~~ 26B-8-124 may prepare typewritten, photographic, electronic, or other reproductions
6838 of vital records and certify their correctness.

6839 (2) Certified copies of the vital record, or authorized reproductions of the original,
6840 issued by either the state registrar or a designated local registrar are prima facie evidence in all
6841 courts of the state with like effect as the vital record.

6842 Section 205. Section **26B-8-130**, which is renumbered from Section 26-2-27 is
6843 renumbered and amended to read:

6844 ~~[26-2-27]~~. **26B-8-130**. **Identifying birth certificates of missing persons --**
6845 **Procedures.**

6846 (1) As used in this section:

6847 (a) "Division" means the Criminal Investigations and Technical Services Division,
6848 Department of Public Safety, in Title 53, Chapter 10, Criminal Investigations and Technical
6849 Services Act.

6850 (b) "Missing child" means a person younger than 18 years ~~[of age]~~ old who is missing
6851 from the person's home environment or a temporary placement facility for any reason, and
6852 whose whereabouts cannot be determined by the person responsible for the child's care.

6853 (c) "Missing person" means a person who:

6854 (i) is missing from the person's home environment; and

6855 (ii) (A) has a physical or mental disability;

6856 (B) is missing under circumstances that indicate that the person is endangered, missing
6857 involuntarily, or a victim of a catastrophe; or

6858 (C) is a missing child.

6859 (2) (a) In accordance with Section 53-10-203, upon the state registrar's notification by

6860 the division that a person who was born in this state is missing, the state and local registrars
6861 shall flag the registered birth certificate of that person so that when a copy of the registered
6862 birth certificate or information regarding the birth record is requested, the state and local
6863 registrars are alerted to the fact the registered birth certificate is that of a missing person.

6864 (b) Upon notification by the division the missing person has been recovered, the state
6865 and local registrars shall remove the flag from that person's registered birth certificate.

6866 (3) The state and local registrars may not provide a copy of a registered birth certificate
6867 of any person whose record is flagged under Subsection (2), except as approved by the
6868 division.

6869 (4) (a) When a copy of the registered birth certificate of a person whose record has
6870 been flagged is requested in person, the state or local registrar shall require that person to
6871 complete a form supplying that person's name, address, telephone number, and relationship to
6872 the missing person, and the name and birth date of the missing person.

6873 (b) The state or local registrar shall inform the requester that a copy of the registered
6874 birth certificate will be mailed to the requester.

6875 (c) The state or local registrar shall note the physical description of the person making
6876 the request, and shall immediately notify the division of the request and the information
6877 obtained pursuant to this Subsection (4).

6878 (5) When a copy of the registered birth certificate of a person whose record has been
6879 flagged is requested in writing, the state or local registrar or personnel of the state or local
6880 registrar shall immediately notify the division, and provide it with a copy of the written request.

6881 Section 206. Section **26B-8-131**, which is renumbered from Section 26-2-28 is
6882 renumbered and amended to read:

6883 ~~[26-2-28]~~. **26B-8-131**. **Birth certificate for foreign adoptees.**

6884 Upon presentation of a court order of adoption and an order establishing the fact, time,
6885 and place of birth under Section ~~[26-2-15]~~ 26B-6-119, the department shall prepare a birth
6886 certificate for an individual who:

6887 (1) was adopted under the laws of this state; and
6888 (2) was at the time of adoption, as a child or as an adult, considered an alien child or
6889 adult for whom the court received documentary evidence of lawful admission under Section
6890 [78B-6-108](#).

6891 Section 207. Section **26B-8-132**, which is renumbered from Section 26-34-4 is
6892 renumbered and amended to read:

6893 ~~[26-34-4]~~. **26B-8-132. Determination of death made by registered nurse.**

6894 (1) As used in this section[~~:(a) "Health care facility" means the same as that term is~~
6895 ~~defined in Section [26-21-2](#). (b) "Physician" means a physician licensed under: (i) Title 58,~~
6896 ~~Chapter 67, Utah Medical Practice Act; or (ii) Title 58, Chapter 68, Utah Osteopathic Medical~~
6897 ~~Practice Act. (c) "Registered", "registered nurse" means a registered nurse licensed under Title~~
6898 ~~58, Chapter 31b, Nurse Practice Act.~~

6899 (2) (a) An individual is dead if the individual has sustained either:
6900 (i) irreversible cessation of circulatory and respiratory functions; or
6901 (ii) irreversible cessation of all functions of the entire brain, including the brain stem.
6902 (b) A determination of death shall be made in accordance with this part and accepted
6903 medical standards.

6904 ~~[(2)]~~ (3) A registered nurse may make a determination of death of an individual if:

6905 (a) an attending physician has:
6906 (i) documented in the individual's medical or clinical record that the individual's death
6907 is anticipated due to illness, infirmity, or disease no later than 180 days after the day on which
6908 the physician makes the documentation; and

6909 (ii) established clear assessment procedures for determining death;
6910 (b) the death actually occurs within the 180-day period described in Subsection ~~[(2)]~~

6911 (3)(a); and

6912 (c) at the time of the documentation described in Subsection ~~[(2)]~~ (3)(a), the physician
6913 authorized the following, in writing, to make the determination of death:

6914 (i) one or more specific registered nurses; or
 6915 (ii) if the individual is in a health care facility that has complied with Subsection ~~[(5)]~~
 6916 (6), all registered nurses that the facility employs.

6917 ~~[(3)]~~ (4) A registered nurse who has determined death under this section shall:

6918 (a) document the clinical criteria for the determination in the individual's medical or
 6919 clinical record;

6920 (b) notify the physician described in Subsection ~~[(2)]~~ (3); and

6921 (c) ensure that the death certificate includes:

6922 (i) the name of the deceased;

6923 (ii) the presence of a contagious disease, if known; and

6924 (iii) the date and time of death.

6925 ~~[(4)]~~ (5) Except as otherwise provided by law or rule, a physician ~~[licensed under Title~~
 6926 ~~58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 68, Utah Osteopathic Medical~~
 6927 ~~Practice Act,]~~ shall certify a determination of death described in Subsection ~~[(3)]~~ (4) within 24
 6928 hours after the registered nurse makes the determination of death.

6929 ~~[(5)]~~ (6) (a) For a health care facility to be eligible for a general authorization described
 6930 in Subsection ~~[(2)]~~ (3)(c), the facility shall adopt written policies and procedures that provide
 6931 for the determination of death by a registered nurse under this section.

6932 (b) A registered nurse that a health care facility employs may not make a determination
 6933 of death under this section unless the facility has adopted the written policies and procedures
 6934 described in Subsection ~~[(5)]~~ (6)(a).

6935 ~~[(6)]~~ (7) The department may make rules, in accordance with Title 63G, Chapter 3,
 6936 Utah Administrative Rulemaking Act, to ensure the appropriate determination of death under
 6937 this section.

6938 Section 208. Section **26B-8-133**, which is renumbered from Section 26-23-5 is
 6939 renumbered and amended to read:

6940 ~~[26-23-5].~~ **26B-8-133. Unlawful acts concerning certificates, records, and**

6941 **reports -- Unlawful transportation or acceptance of dead human body.**

6942 It is unlawful for any person, association, or corporation and the officers of any of them:

6943 (1) to willfully and knowingly make any false statement in a certificate, record, or
6944 report required to be filed with the department, or in an application for a certified copy of a
6945 vital record, or to willfully and knowingly supply false information intending that the
6946 information be used in the preparation of any report, record, or certificate, or an amendment to
6947 any of these;

6948 (2) to make, counterfeit, alter, amend, or mutilate any certificate, record, or report
6949 required to be filed under this code or a certified copy of the certificate, record, or report
6950 without lawful authority and with the intent to deceive;

6951 (3) to willfully and knowingly obtain, possess, use, sell, furnish, or attempt to obtain,
6952 possess, use, sell, or furnish to another, for any purpose of deception, any certificate, record,
6953 report, or certified copy of any of them, including any that are counterfeited, altered, amended,
6954 or mutilated;

6955 (4) without lawful authority, to possess any certificate, record, or report, required by
6956 the department or a copy or certified copy of the certificate, record, or report, knowing it to
6957 have been stolen or otherwise unlawfully obtained; or

6958 (5) to willfully and knowingly transport or accept for transportation, interment, or other
6959 disposition a dead human body without a permit required by law.

6960 Section 209. Section **26B-8-134**, which is renumbered from Section 26-23-5.5 is
6961 renumbered and amended to read:

6962 **~~[26-23-5.5].~~ 26B-8-134. **Illegal use of birth certificate -- Penalties.****

6963 (1) It is a third degree felony for any person to willfully and knowingly:

6964 (a) and with the intent to deceive, obtain, possess, use, sell, furnish, or attempt to
6965 obtain, possess, use, sell, or furnish to another any certificate of birth or certified copy of a
6966 certificate of birth knowing that the certificate or certified copy was issued upon information
6967 which is false in whole or in part or which relates to the birth of another person, whether living

6968 or deceased; or

6969 (b) furnish or process a certificate of birth or certified copy of a certificate of birth with
6970 the knowledge or intention that it be used for the purpose of deception by a person other than
6971 the person to whom the certificate of birth relates.

6972 (2) The specific criminal violations and the criminal penalty under this section take
6973 precedence over any more general criminal offense as described in Section [~~26-23-5~~]
6974 [26B-8-133](#).

6975 Section 210. Section **26B-8-201**, which is renumbered from Section 26-4-2 is
6976 renumbered and amended to read:

6977 **Part 2. Utah Medical Examiner**

6978 [~~26-4-2~~]. **26B-8-201. Definitions.**

6979 As used in this [~~chapter~~] part:

6980 (1) "Dead body" means the same as that term is defined in Section [~~26-2-2~~] [26B-8-101](#).

6981 (2) (a) "Death by violence" means death that resulted by the decedent's exposure to
6982 physical, mechanical, or chemical forces.

6983 (b) "Death by violence" includes death that appears to have been due to homicide,
6984 death that occurred during or in an attempt to commit rape, mayhem, kidnapping, robbery,
6985 burglary, housebreaking, extortion, or blackmail accompanied by threats of violence, assault
6986 with a dangerous weapon, assault with intent to commit any offense punishable by
6987 imprisonment for more than one year, arson punishable by imprisonment for more than one
6988 year, or any attempt to commit any of the foregoing offenses.

6989 (3) "Immediate relative" means an individual's spouse, child, parent, sibling,
6990 grandparent, or grandchild.

6991 (4) "Health care professional" means any of the following while acting in a
6992 professional capacity:

6993 (a) a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title
6994 58, Chapter 68, Utah Osteopathic Medical Practice Act;

6995 (b) a physician assistant licensed under Title 58, Chapter 70a, Utah Physician Assistant
6996 Act; or

6997 (c) an advance practice registered nurse licensed under Subsection [58-31b-301\(2\)\(e\)](#).

6998 (5) "Medical examiner" means the state medical examiner appointed pursuant to
6999 Section ~~[26-4-4]~~ [26B-8-202](#) or a deputy appointed by the medical examiner.

7000 (6) "Medical examiner record" means:

7001 (a) all information that the medical examiner obtains regarding a decedent; and

7002 (b) reports that the medical examiner makes regarding a decedent.

7003 (7) "Regional pathologist" means a trained pathologist licensed to practice medicine
7004 and surgery in the state, appointed by the medical examiner pursuant to Subsection ~~[26-4-4]~~
7005 [26B-8-202\(3\)](#).

7006 (8) "Sudden death while in apparent good health" means apparently instantaneous
7007 death without obvious natural cause, death during or following an unexplained syncope or
7008 coma, or death during an acute or unexplained rapidly fatal illness.

7009 (9) "Sudden infant death syndrome" means the death of a child who was thought to be
7010 in good health or whose terminal illness appeared to be so mild that the possibility of a fatal
7011 outcome was not anticipated.

7012 (10) "Suicide" means death caused by an intentional and voluntary act of an individual
7013 who understands the physical nature of the act and intends by such act to accomplish
7014 self-destruction.

7015 (11) "Unattended death" means a death that occurs more than 365 days after the day on
7016 which a health care professional examined or treated the deceased individual for any purpose,
7017 including writing a prescription.

7018 (12) (a) "Unavailable for postmortem investigation" means that a dead body is:

7019 (i) transported out of state;

7020 (ii) buried at sea;

7021 (iii) cremated;

7022 (iv) processed by alkaline hydrolysis; or
7023 (v) otherwise made unavailable to the medical examiner for postmortem investigation
7024 or autopsy.

7025 (b) "Unavailable for postmortem investigation" does not include embalming or burial
7026 of a dead body pursuant to the requirements of law.

7027 (13) "Within the scope of the decedent's employment" means all acts reasonably
7028 necessary or incident to the performance of work, including matters of personal convenience
7029 and comfort not in conflict with specific instructions.

7030 Section 211. Section **26B-8-202**, which is renumbered from Section 26-4-4 is
7031 renumbered and amended to read:

7032 ~~[26-4-4]~~. **26B-8-202. Chief medical examiner -- Appointment -- Qualifications**
7033 **-- Authority.**

7034 (1) The executive director, with the advice of an advisory board consisting of the
7035 chairman of the Department of Pathology at the University of Utah medical school and the
7036 dean of the law school at the University of Utah, shall appoint a chief medical examiner who
7037 shall be licensed to practice medicine in the state and shall meet the qualifications of a forensic
7038 pathologist, certified by the American Board of [~~Pathologists~~] Pathology.

7039 (2) (a) The medical examiner shall serve at the will of the executive director.

7040 (b) The medical examiner has authority to:

7041 (i) employ medical, technical and clerical personnel as may be required to effectively
7042 administer this chapter, subject to the rules of the department and the state merit system;

7043 (ii) conduct investigations and pathological examinations;

7044 (iii) perform autopsies authorized in this title;

7045 (iv) conduct or authorize necessary examinations on dead bodies; and

7046 (v) notwithstanding the provisions of Subsection [~~26-28-122~~] 26B-8-321(3), retain
7047 tissues and biological samples:

7048 (A) for scientific purposes;

7049 (B) where necessary to accurately certify the cause and manner of death; or
7050 (C) for tissue from an unclaimed body, subject to Section [~~26-4-25~~] 26B-8-225, in
7051 order to donate the tissue or biological sample to an individual who is affiliated with an
7052 established search and rescue dog organization, for the purpose of training a dog to search for
7053 human remains.

7054 (c) In the case of an unidentified body, the medical examiner shall authorize or conduct
7055 investigations, tests and processes in order to determine its identity as well as the cause of
7056 death.

7057 (3) The medical examiner may appoint regional pathologists, each of whom shall be
7058 approved by the executive director.

7059 Section 212. Section **26B-8-203**, which is renumbered from Section 26-4-5 is
7060 renumbered and amended to read:

7061 [~~26-4-5~~]. **26B-8-203. County medical examiners.**

7062 The county executive, with the advice and consent of the county legislative body, may
7063 appoint medical examiners for their respective counties.

7064 Section 213. Section **26B-8-204**, which is renumbered from Section 26-4-6 is
7065 renumbered and amended to read:

7066 [~~26-4-6~~]. **26B-8-204. Investigation of deaths -- Requests for autopsies.**

7067 (1) The following have authority to investigate a death described in Section [~~26-4-7~~]
7068 26B-8-205 and any other case which may be within their jurisdiction:

- 7069 (a) the attorney general or an assistant attorney general;
- 7070 (b) the district attorney or county attorney who has criminal jurisdiction over the death
7071 or case;
- 7072 (c) a deputy of the district attorney or county attorney described in Subsection (1)(b);
7073 or
- 7074 (d) a peace officer within the jurisdiction described in Subsection (1)(b).

7075 (2) If, in the opinion of the medical examiner, an autopsy should be performed or if an

7076 autopsy is requested by the district attorney or county attorney having criminal jurisdiction, or
7077 by the attorney general, the autopsy shall be performed by the medical examiner or a regional
7078 pathologist.

7079 Section 214. Section **26B-8-205**, which is renumbered from Section 26-4-7 is
7080 renumbered and amended to read:

7081 ~~[26-4-7]~~. **26B-8-205. Custody by medical examiner.**

7082 Upon notification under Section ~~[26-4-8]~~ [26B-8-206](#) or investigation by the medical
7083 examiner's office, the medical examiner shall assume custody of a deceased body if it appears
7084 that death:

- 7085 (1) was by violence, gunshot, suicide, or accident;
- 7086 (2) was sudden death while in apparent good health;
- 7087 (3) occurred unattended, except that an autopsy may only be performed in accordance
7088 with the provisions of Subsection ~~[26-4-9]~~ [26B-8-207](#)(3);
- 7089 (4) occurred under suspicious or unusual circumstances;
- 7090 (5) resulted from poisoning or overdose of drugs;
- 7091 (6) resulted from a disease that may constitute a threat to the public health;
- 7092 (7) resulted from disease, injury, toxic effect, or unusual exertion incurred within the
7093 scope of the decedent's employment;
- 7094 (8) was due to sudden infant death syndrome;
- 7095 (9) occurred while the decedent was in prison, jail, police custody, the state hospital, or
7096 in a detention or medical facility operated for the treatment of persons with a mental illness,
7097 persons who are emotionally disturbed, or delinquent persons;
- 7098 (10) resulted directly from the actions of a law enforcement officer, as defined in
7099 Section [53-13-103](#);
- 7100 (11) was associated with diagnostic or therapeutic procedures; or
- 7101 (12) was described in this section when request is made to assume custody by a county
7102 or district attorney or law enforcement agency in connection with a potential homicide

7103 investigation or prosecution.

7104 Section 215. Section **26B-8-206**, which is renumbered from Section 26-4-8 is
7105 renumbered and amended to read:

7106 ~~[26-4-8]~~. **26B-8-206. Discovery of dead body -- Notice requirements --**
7107 **Procedure.**

7108 (1) When death occurs under circumstances listed in Section ~~[26-4-7]~~ 26B-8-205, the
7109 person or persons finding or having custody of the body shall immediately notify the nearest
7110 law enforcement agency. The law enforcement agency having jurisdiction over the case shall
7111 then proceed to the place where the body is and conduct an investigation concerning the cause
7112 and circumstances of death for the purpose of determining whether there exists any criminal
7113 responsibility for the death.

7114 (2) On a determination by the law enforcement agency that death may have occurred in
7115 any of the ways described in Section ~~[26-4-7]~~ 26B-8-205, the death shall be reported to the
7116 district attorney or county attorney having criminal jurisdiction and to the medical examiner by
7117 the law enforcement agency having jurisdiction over the investigation.

7118 (3) The report shall be made by the most expeditious means available. Failure to give
7119 notification or report to the district attorney or county attorney having criminal jurisdiction and
7120 medical examiner is a class B misdemeanor.

7121 Section 216. Section **26B-8-207**, which is renumbered from Section 26-4-9 is
7122 renumbered and amended to read:

7123 ~~[26-4-9]~~. **26B-8-207. Custody of dead body and personal effects --**
7124 **Examination of scene of death -- Preservation of body -- Autopsies.**

7125 (1) (a) Upon notification of a death under Section ~~[26-4-8]~~ 26B-8-206, the medical
7126 examiner shall assume custody of the deceased body, clothing on the body, biological samples
7127 taken, and any article on or near the body which may aid the medical examiner in determining
7128 the cause of death except those articles which will assist the investigative agency to proceed
7129 without delay with the investigation.

7130 (b) In all cases the scene of the event may not be disturbed until authorization is given
7131 by the senior ranking peace officer from the law enforcement agency having jurisdiction of the
7132 case and conducting the investigation.

7133 (c) Where death appears to have occurred under circumstances listed in Section
7134 ~~[26-4-7]~~ [26B-8-205](#), the person or persons finding or having custody of the body, or
7135 jurisdiction over the investigation of the death, shall take reasonable precautions to preserve the
7136 body and body fluids so that minimum deterioration takes place.

7137 (d) A person may not move a body in the custody of the medical examiner unless:

7138 (i) the medical examiner, or district attorney or county attorney that has criminal
7139 jurisdiction, authorizes the person to move the body;

7140 (ii) a designee of an individual listed in this Subsection (1)(d) authorizes the person to
7141 move the body;

7142 (iii) not moving the body would be an affront to public decency or impractical; or

7143 (iv) the medical examiner determines the cause of death is likely due to natural causes.

7144 (e) The body can under direction of the medical examiner or the medical examiner's
7145 designee be moved to a place specified by the medical examiner or the medical examiner's
7146 designee.

7147 (2) (a) If the medical examiner has custody of a body, a person may not clean or
7148 embalm the body without first obtaining the medical examiner's permission.

7149 (b) An intentional or knowing violation of Subsection (2)(a) is a class B misdemeanor.

7150 (3) (a) When the medical examiner assumes lawful custody of a body under Subsection
7151 ~~[26-4-7]~~ [26B-8-205](#)(3) solely because the death was unattended, an autopsy may not be
7152 performed unless requested by the district attorney, county attorney having criminal
7153 jurisdiction, or law enforcement agency having jurisdiction of the place where the body is
7154 found.

7155 (b) The county attorney or district attorney and law enforcement agency having
7156 jurisdiction shall consult with the medical examiner to determine the need for an autopsy.

7157 (c) If the deceased chose not to be seen or treated by a health care professional for a
7158 spiritual or religious reason, a district attorney, county attorney, or law enforcement agency,
7159 may not request an autopsy or inquest under Subsection (3)(a) solely because of the deceased's
7160 choice.

7161 (d) The medical examiner or medical examiner's designee may not conduct a requested
7162 autopsy described in Subsection (3)(a) if the medical examiner or medical examiner's designee
7163 determines:

7164 (i) the request violates Subsection (3)(c); or

7165 (ii) the cause of death can be determined without performing an autopsy.

7166 Section 217. Section **26B-8-208**, which is renumbered from Section 26-2-18.5 is
7167 renumbered and amended to read:

7168 ~~[26-2-18.5]~~. **26B-8-208**. **Rendering a dead body unavailable for postmortem**
7169 **investigation.**

7170 (1) As used in this section:

7171 (a) "Medical examiner" means the same as that term is defined in Section ~~[26-4-2]~~
7172 26B-8-201.

7173 (b) "Unavailable for postmortem investigation" means the same as that term is defined
7174 in Section ~~[26-4-2]~~ 26B-8-201.

7175 (2) It is unlawful for a person to engage in any conduct that makes a dead body
7176 unavailable for postmortem investigation, unless, before engaging in that conduct, the person
7177 obtains a permit from the medical examiner to render the dead body unavailable for
7178 postmortem investigation, under Section ~~[26-4-29]~~ 26B-8-230, if the person intends to make
7179 the body unavailable for postmortem investigation.

7180 (3) A person who violates Subsection (2) is guilty of a third degree felony.

7181 (4) If a person engages in conduct that constitutes both a violation of this section and a
7182 violation of Section 76-9-704, the provisions and penalties of Section 76-9-704 supersede the
7183 provisions and penalties of this section.

7184 Section 218. Section **26B-8-209**, which is renumbered from Section 26-4-10 is
7185 renumbered and amended to read:

7186 ~~[26-4-10]~~. **26B-8-209**. **Certification of cause of death.**

7187 (1) (a) For a death under any of the circumstances described in Section ~~[26-4-7]~~
7188 26B-8-205, only the medical examiner or the medical examiner's designee may certify the
7189 cause of death.

7190 (b) An individual who knowingly certifies the cause of death in violation of Subsection
7191 (1)(a) is guilty of a class B misdemeanor.

7192 (2) (a) For a death described in Section ~~[26-4-7]~~ 26B-8-205, an individual may not
7193 knowingly give false information, with the intent to mislead, to the medical examiner or the
7194 medical examiner's designee.

7195 (b) A violation of Subsection (2)(a) is a class B misdemeanor.

7196 Section 219. Section **26B-8-210**, which is renumbered from Section 26-4-10.5 is
7197 renumbered and amended to read:

7198 ~~[26-4-10.5]~~. **26B-8-210**. **Medical examiner to report death caused by prescribed**
7199 **controlled substance poisoning or overdose.**

7200 (1) If a medical examiner determines that the death of a person who is 12 years old or
7201 older at the time of death resulted from poisoning or overdose involving a prescribed controlled
7202 substance, the medical examiner shall, within three business days after the day on which the
7203 medical examiner determines the cause of death, send a written report to the Division of
7204 Professional Licensing, created in Section 58-1-103, that includes:

7205 (a) the decedent's name;

7206 (b) each drug or other substance found in the decedent's system that may have
7207 contributed to the poisoning or overdose, if known; and

7208 (c) the name of each person the medical examiner has reason to believe may have
7209 prescribed a controlled substance described in Subsection (1)(b) to the decedent.

7210 (2) This section does not create a new cause of action.

7211 Section 220. Section **26B-8-211**, which is renumbered from Section 26-4-11 is
7212 renumbered and amended to read:

7213 ~~[26-4-11]~~. **26B-8-211. Records and reports of investigations.**

7214 (1) A complete copy of all written records and reports of investigations and facts
7215 resulting from medical care treatment, autopsies conducted by any person on the body of the
7216 deceased who died in any manner listed in Section ~~[26-4-7]~~ 26B-8-205 and the written reports
7217 of any investigative agency making inquiry into the incident shall be promptly made and filed
7218 with the medical examiner.

7219 (2) The judiciary or a state or local government entity that retains a record, other than a
7220 document described in Subsection (1), of the decedent shall provide a copy of the record to the
7221 medical examiner:

7222 (a) in accordance with federal law; and

7223 (b) upon receipt of the medical examiner's written request for the record.

7224 (3) Failure to submit reports or records described in Subsection (1) or (2), other than
7225 reports of a county attorney, district attorney, or law enforcement agency, within 10 days after
7226 the day on which the person in possession of the report or record receives the medical
7227 examiner's written request for the report or record is a class B misdemeanor.

7228 Section 221. Section **26B-8-212**, which is renumbered from Section 26-4-12 is
7229 renumbered and amended to read:

7230 ~~[26-4-12]~~. **26B-8-212. Order to exhume body -- Procedure.**

7231 (1) In case of any death described in Section ~~[26-4-7]~~ 26B-8-205, when a body is
7232 buried without an investigation by the medical examiner as to the cause and manner of death, it
7233 shall be the duty of the medical examiner, upon being advised of the fact, to notify the district
7234 attorney or county attorney having criminal jurisdiction where the body is buried or death
7235 occurred. Upon notification, the district attorney or county attorney having criminal
7236 jurisdiction may file an action in the district court to obtain an order to exhume the body. A
7237 district judge may order the body exhumed upon an ex parte hearing.

7238 (2) (a) A body may not be exhumed until notice of the order has been served upon the
7239 executor or administrator of the deceased's estate, or if no executor or administrator has been
7240 appointed, upon the nearest heir of the deceased, determined as if the deceased had died
7241 intestate. If the nearest heir of the deceased cannot be located within the jurisdiction, then the
7242 next heir in succession within the jurisdiction may be served.

7243 (b) The executor, administrator, or heir shall have 24 hours to notify the issuing court
7244 of any objection to the order prior to the time the body is exhumed. If no heirs can be located
7245 within the jurisdiction within 24 hours, the facts shall be reported to the issuing court which
7246 may order that the body be exhumed forthwith.

7247 (c) Notification to the executor, administrator, or heir shall specifically state the nature
7248 of the action and the fact that any objection shall be filed with the issuing court within 24 hours
7249 of the time of service.

7250 (d) In the event an heir files an objection, the court shall set hearing on the matter at the
7251 earliest possible time and issue an order on the matter immediately at the conclusion of the
7252 hearing. Upon the receipt of notice of objection, the court shall immediately notify the county
7253 attorney who requested the order, so that the interest of the state may be represented at the
7254 hearing.

7255 (e) When there is reason to believe that death occurred in a manner described in
7256 Section [~~26-4-7~~] [26B-8-205](#), the district attorney or county attorney having criminal
7257 jurisdiction may make a motion that the court, upon ex parte hearing, order the body exhumed
7258 forthwith and without notice. Upon a showing of exigent circumstances the court may order
7259 the body exhumed forthwith and without notice. In any event, upon motion of the district
7260 attorney or county attorney having criminal jurisdiction and upon the personal appearance of
7261 the medical examiner, the court for good cause may order the body exhumed forthwith and
7262 without notice.

7263 (3) An order to exhume a body shall be directed to the medical examiner, commanding
7264 the medical examiner to cause the body to be exhumed, perform the required autopsy, and

7265 properly cause the body to be reburied upon completion of the examination.

7266 (4) The examination shall be completed and the complete autopsy report shall be made
7267 to the district attorney or county attorney having criminal jurisdiction for any action the
7268 attorney considers appropriate. The district attorney or county attorney shall submit the return
7269 of the order to exhume within 10 days in the manner prescribed by the issuing court.

7270 Section 222. Section **26B-8-213**, which is renumbered from Section 26-4-13 is
7271 renumbered and amended to read:

7272 ~~[26-4-13]~~. **26B-8-213. Autopsies -- When authorized.**

7273 (1) The medical examiner shall perform an autopsy to:

- 7274 (a) aid in the discovery and prosecution of a crime;
7275 (b) protect an innocent person accused of a crime; and
7276 (c) disclose hazards to public health.

7277 (2) The medical examiner may perform an autopsy:

- 7278 (a) to aid in the administration of civil justice in life and accident insurance problems
7279 in accordance with Title 34A, Chapter 2, Workers' Compensation Act; and
7280 (b) in other cases involving questions of civil liability.

7281 Section 223. Section **26B-8-214**, which is renumbered from Section 26-4-14 is
7282 renumbered and amended to read:

7283 ~~[26-4-14]~~. **26B-8-214. Certification of death by attending health care
7284 professional -- Deaths without medical attendance -- Cause of death uncertain -- Notice
7285 requirements.**

7286 (1) (a) A health care professional who treats or examines an individual within 365 days
7287 from the day on which the individual dies, shall certify the individual's cause of death to the
7288 best of the health care professional's knowledge and belief unless the health care professional
7289 determines the individual may have died in a manner described in Section ~~[26-4-7]~~ [26B-8-205](#).

7290 (b) If a health care professional is unable to determine an individual's cause of death in
7291 accordance with Subsection (1)(a), the health care professional shall notify the medical

7292 examiner.

7293 (2) For an unattended death, the person with custody of the body shall notify the
7294 medical examiner of the death.

7295 (3) If the medical examiner determines there may be criminal responsibility for a death,
7296 the medical examiner shall notify:

7297 (a) the district attorney or county attorney that has criminal jurisdiction; or

7298 (b) the head of the law enforcement agency that has jurisdiction to investigate the
7299 death.

7300 Section 224. Section **26B-8-215**, which is renumbered from Section 26-4-15 is
7301 renumbered and amended to read:

7302 ~~[26-4-15]~~. **26B-8-215**. **Deaths in medical centers and federal facilities.**

7303 All death certificates of any decedent who died in a teaching medical center or a federal
7304 medical facility unattended or in the care of an unlicensed physician or other medical personnel
7305 shall be signed by the licensed supervisory physician, attending physician or licensed resident
7306 physician of the medical center or facility.

7307 Section 225. Section **26B-8-216**, which is renumbered from Section 26-4-16 is
7308 renumbered and amended to read:

7309 ~~[26-4-16]~~. **26B-8-216**. **Release of body for funeral preparations.**

7310 (1) (a) Where a body is held for investigation or autopsy under this chapter or for a
7311 medical investigation permitted by law, the body shall, if requested by the person given priority
7312 under Section [58-9-602](#), be released for funeral preparations no later than 24 hours after the
7313 arrival at the office of the medical examiner or regional medical facility.

7314 (b) An extension may be ordered only by a district court.

7315 (2) The right and duty to control the disposition of a deceased person is governed by
7316 Sections [58-9-601](#) through [58-9-606](#).

7317 Section 226. Section **26B-8-217**, which is renumbered from Section 26-4-17 is
7318 renumbered and amended to read:

7319 ~~[26-4-17]~~. **26B-8-217. Records of medical examiner -- Confidentiality.**

7320 (1) The medical examiner shall maintain complete, original records for the medical
7321 examiner record, which shall:

7322 (a) be properly indexed, giving the name, if known, or otherwise identifying every
7323 individual whose death is investigated;

7324 (b) indicate the place where the body was found;

7325 (c) indicate the date of death;

7326 (d) indicate the cause and manner of death;

7327 (e) indicate the occupation of the decedent, if available;

7328 (f) include all other relevant information concerning the death; and

7329 (g) include a full report and detailed findings of the autopsy or report of the
7330 investigation.

7331 (2) (a) Upon written request from an individual described in Subsections (2)(a)(i)
7332 through (iv), the medical examiner shall provide a copy of the medical examiner's final report
7333 of examination for the decedent, including the autopsy report, toxicology report, lab reports,
7334 and investigative reports to any of the following:

7335 (i) a decedent's immediate relative;

7336 (ii) a decedent's legal representative;

7337 (iii) a physician or physician assistant who attended the decedent during the year before
7338 the decedent's death; or

7339 (iv) a county attorney, a district attorney, a criminal defense attorney, or other law
7340 enforcement official with jurisdiction, as necessary for the performance of the attorney or
7341 official's professional duties.

7342 (b) Upon written request from the director or a designee of the director of an entity
7343 described in Subsections (2)(b)(i) through (iv), the medical examiner may provide a copy of the
7344 of the medical examiner's final report of examination for the decedent, including any other
7345 reports described in Subsection (2)(a), to any of the following entities as necessary for

7346 performance of the entity's official purposes:

7347 (i) a local health department;

7348 (ii) a local mental health authority;

7349 (iii) a public health authority; or

7350 (iv) another state or federal governmental agency.

7351 (c) The medical examiner may provide a copy of the medical examiner's final report of
7352 examination, including any other reports described in Subsection (2)(a), if the final report
7353 relates to an issue of public health or safety, as further defined by rule made by the department
7354 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

7355 (3) Reports provided under Subsection (2) may not include records that the medical
7356 examiner obtains from a third party in the course of investigating the decedent's death.

7357 (4) The medical examiner may provide a medical examiner record to a researcher who:

7358 (a) has an advanced degree;

7359 (b) (i) is affiliated with an accredited college or university, a hospital, or another
7360 system of care, including an emergency medical response or a local health agency; or

7361 (ii) is part of a research firm contracted with an accredited college or university, a
7362 hospital, or another system of care;

7363 (c) requests a medical examiner record for a research project or a quality improvement
7364 initiative that will have a public health benefit, as determined by the department; and

7365 (d) provides to the medical examiner an approval from:

7366 (i) the researcher's sponsoring organization; and

7367 (ii) the Utah Department of Health and Human Services Institutional Review Board.

7368 (5) Records provided under Subsection (4) may not include a third party record, unless:

7369 (a) a court has ordered disclosure of the third party record; and

7370 (b) disclosure is conducted in compliance with state and federal law.

7371 (6) A person who obtains a medical examiner record under Subsection (4) shall:

7372 (a) maintain the confidentiality of the medical examiner record by removing personally

7373 identifying information about a decedent or the decedent's family and any other information
7374 that may be used to identify a decedent before using the medical examiner record in research;

7375 (b) conduct any research within and under the supervision of the Office of the Medical
7376 Examiner, if the medical examiner record contains a third party record with personally
7377 identifiable information;

7378 (c) limit the use of a medical examiner record to the purpose for which the person
7379 requested the medical examiner record;

7380 (d) destroy a medical examiner record and the data abstracted from the medical
7381 examiner record at the conclusion of the research for which the person requested the medical
7382 examiner record;

7383 (e) reimburse the medical examiner, as provided in Section [26B-1-209](#), for any costs
7384 incurred by the medical examiner in providing a medical examiner record;

7385 (f) allow the medical examiner to review, before public release, a publication in which
7386 data from a medical examiner record is referenced or analyzed; and

7387 (g) provide the medical examiner access to the researcher's database containing data
7388 from a medical examiner record, until the day on which the researcher permanently destroys
7389 the medical examiner record and all data obtained from the medical examiner record.

7390 (7) The department may make rules, in accordance with Title 63G, Chapter 3, Utah
7391 Administrative Rulemaking Act, and in consideration of applicable state and federal law, to
7392 establish permissible uses and disclosures of a medical examiner record or other record
7393 obtained under this section.

7394 (8) Except as provided in this chapter or ordered by a court, the medical examiner may
7395 not disclose any part of a medical examiner record.

7396 (9) A person who obtains a medical examiner record under Subsection (4) is guilty of a
7397 class B misdemeanor, if the person fails to comply with the requirements of Subsections (6)(a)
7398 through (d).

7399 Section 227. Section **26B-8-218**, which is renumbered from Section 26-4-18 is

7400 renumbered and amended to read:

7401 ~~[26-4-18]~~. **26B-8-218**. **Records of medical examiner -- Admissibility as**
7402 **evidence -- Subpoena of person who prepared record.**

7403 The records of the medical examiner or transcripts thereof certified by the medical
7404 examiner are admissible as evidence in any civil action in any court in this state except that
7405 statements by witnesses or other persons, unless taken pursuant to Section ~~[26-4-21]~~
7406 26B-8-221, as conclusions upon extraneous matters are not hereby made admissible. The
7407 person who prepared a report or record offered in evidence hereunder may be subpoenaed as a
7408 witness in the case by any party.

7409 Section 228. Section **26B-8-219**, which is renumbered from Section 26-4-19 is
7410 renumbered and amended to read:

7411 ~~[26-4-19]~~. **26B-8-219**. **Personal property of deceased -- Disposition.**

7412 (1) Personal property of the deceased not held as evidence shall be turned over to the
7413 legal representative of the deceased within 30 days after completion of the investigation of the
7414 death of the deceased. If no legal representative is known, the county attorney, district attorney,
7415 or the medical examiner shall, within 30 days after the investigation, turn the personal property
7416 over to the county treasurer to be handled pursuant to the escheat laws.

7417 (2) An affidavit shall be filed with the county treasurer by the county attorney, district
7418 attorney, or the medical examiner within 30 days after investigation of the death of the
7419 deceased showing the money or other property belonging to the estate of the deceased person
7420 which has come into his possession and the disposition made of the property.

7421 (3) Property required to be turned over to the legal representative of the deceased may
7422 be held longer than 30 days if, in the opinion of the county attorney, district attorney, or
7423 attorney general, the property is necessary evidence in a court proceeding. Upon conclusion of
7424 the court proceedings, the personal property shall be turned over as described in this section
7425 and in accordance with the rules of the court.

7426 Section 229. Section **26B-8-220**, which is renumbered from Section 26-4-20 is

7427 renumbered and amended to read:

7428 ~~[26-4-20]~~. **26B-8-220. Officials not liable for authorized acts.**

7429 Except as provided in this ~~[chapter]~~ part, a criminal or civil action may not arise against
7430 the county attorney, district attorney, or his deputies, the medical examiner or his deputies, or
7431 regional pathologists for authorizing or performing autopsies authorized by this ~~[chapter]~~ part
7432 or for any other act authorized by this ~~[chapter]~~ part.

7433 Section 230. Section **26B-8-221**, which is renumbered from Section 26-4-21 is
7434 renumbered and amended to read:

7435 ~~[26-4-21]~~. **26B-8-221. Authority of county attorney or district attorney to**
7436 **subpoena witnesses and compel testimony -- Determination if decedent died by unlawful**
7437 **means.**

7438 (1) The district attorney or county attorney having criminal jurisdiction may subpoena
7439 witnesses and compel testimony concerning the death of any person and have such testimony
7440 reduced to writing under his direction and may employ a shorthand reporter for that purpose at
7441 the same compensation as is allowed to reporters in the district courts. When the testimony has
7442 been taken down by the shorthand reporter, a transcript thereof, duly certified, shall constitute
7443 the deposition of the witness.

7444 (2) Upon review of all facts and testimony taken concerning the death of a person, the
7445 district attorney or county attorney having criminal jurisdiction shall determine if the decedent
7446 died by unlawful means and shall also determine if criminal prosecution shall be instituted.

7447 Section 231. Section **26B-8-222**, which is renumbered from Section 26-4-22 is
7448 renumbered and amended to read:

7449 ~~[26-4-22]~~. **26B-8-222. Additional powers and duties of department.**

7450 The department may:

7451 (1) establish rules to carry out the provisions of this ~~[chapter]~~ part;

7452 (2) arrange for the state health laboratory to perform toxicologic analysis for public or
7453 private institutions and fix fees for the services;

7454 (3) cooperate and train law enforcement personnel in the techniques of criminal
7455 investigation as related to medical and pathological matters; and

7456 (4) pay to private parties, institutions or funeral directors the reasonable value of
7457 services performed for the medical examiner's office.

7458 Section 232. Section **26B-8-223**, which is renumbered from Section 26-4-23 is
7459 renumbered and amended to read:

7460 ~~[26-4-23]~~. **26B-8-223**. **Authority of examiner to provide organ or other tissue**
7461 **for transplant purposes.**

7462 (1) When requested by the licensed physician of a patient who is in need of an organ or
7463 other tissue for transplant purpose, by a legally created Utah eye bank, organ bank or medical
7464 facility, the medical examiner may provide an organ or other tissue if:

7465 (a) a decedent who may provide a suitable organ or other tissue for the transplant is in
7466 the custody of the medical examiner;

7467 (b) the medical examiner is assured that the requesting party has made reasonable
7468 search for and inquiry of next of kin of the decedent and that no objection by the next of kin is
7469 known by the requesting party; and

7470 (c) the removal of the organ or other tissue will not interfere with the investigation or
7471 autopsy or alter the post-mortem facial appearance.

7472 (2) When the medical examiner is in custody of a decedent who may provide a suitable
7473 organ or other tissue for transplant purposes, he may contact the appropriate eye bank, organ
7474 bank or medical facility and notify them concerning the suitability of the organ or other tissue.
7475 In such contact the medical examiner may disclose the name of the decedent so that necessary
7476 clearances can be obtained.

7477 (3) No person shall be held civilly or criminally liable for any acts performed pursuant
7478 to this section.

7479 Section 233. Section **26B-8-224**, which is renumbered from Section 26-4-24 is
7480 renumbered and amended to read:

7481 ~~[26-4-24]~~. **26B-8-224. Autopsies -- Persons eligible to authorize.**

7482 (1) Autopsies may be authorized:

7483 (a) by the commissioner of the Labor Commission or the commissioner's designee as

7484 provided in Section [34A-2-603](#);

7485 (b) by individuals by will or other written document;

7486 (c) upon a decedent by the next of kin in the following order and as known: surviving

7487 spouse, child, if 18 years old or older, otherwise the legal guardian of the child, parent, sibling,

7488 uncle or aunt, nephew or niece, cousin, others charged by law with the duty of burial, or friend

7489 assuming the obligation of burial;

7490 (d) by the county attorney, district attorney, or the district attorney's deputy, or a district

7491 judge; and

7492 (e) by the medical examiner as provided in this ~~[chapter]~~ part.

7493 (2) Autopsies authorized under Subsections (1)(a) and (1)(d) shall be performed by a

7494 certified pathologist.

7495 (3) No criminal or civil action arises against a pathologist or a physician who proceeds

7496 in good faith and performs an autopsy authorized by this section.

7497 Section 234. Section **26B-8-225**, which is renumbered from Section 26-4-25 is

7498 renumbered and amended to read:

7499 ~~[26-4-25]~~. **26B-8-225. Burial of an unclaimed body -- Request by the school of**

7500 **medicine at the University of Utah -- Medical examiner may retain tissue for dog**

7501 **training.**

7502 (1) Except as described in Subsection (2) or (3), a county shall provide, at the county's

7503 expense, decent burial for an unclaimed body found in the county.

7504 (2) A county is not responsible for decent burial of an unclaimed body found in the

7505 county if the body is requested by the dean of the school of medicine at the University of Utah

7506 under Section [53B-17-301](#).

7507 (3) For an unclaimed body that is temporarily in the medical examiner's custody before

7508 burial under Subsection (1), the medical examiner may retain tissue from the unclaimed body
7509 in order to donate the tissue to an individual who is affiliated with an established search and
7510 rescue dog organization, for the purpose of training a dog to search for human remains.

7511 Section 235. Section **26B-8-226**, which is renumbered from Section 26-4-26 is
7512 renumbered and amended to read:

7513 ~~[26-4-26]~~. **26B-8-226**. **Social security number in certification of death.**

7514 A certification of death shall include, if known, the social security number of the
7515 deceased person, and a copy of the certification shall be sent to the Office of Recovery Services
7516 within the [~~Department of Human Services~~] department upon request.

7517 Section 236. Section **26B-8-227**, which is renumbered from Section 26-4-27 is
7518 renumbered and amended to read:

7519 ~~[26-4-27]~~. **26B-8-227**. **Registry of unidentified deceased persons.**

7520 (1) If the identity of a deceased person over which the medical examiner has
7521 jurisdiction under Section [~~26-4-7~~] 26B-8-205 is unknown, the medical examiner shall do the
7522 following before releasing the body to the county in which the body was found as provided in
7523 Section [~~26-4-25~~] 26B-8-225:

7524 (a) assign a unique identifying number to the body;

7525 (b) create and maintain a file under the assigned number;

7526 (c) examine the body, take samples, and perform other related tasks for the purpose of
7527 deriving information that may be useful in ascertaining the identity of the deceased person;

7528 (d) use the identifying number in all records created by the medical examiner that
7529 pertains to the body;

7530 (e) record all information pertaining to the body in the file created and maintained
7531 under Subsection (1)(b);

7532 (f) communicate the unique identifying number to the county in which the body was
7533 found; and

7534 (g) access information from available government sources and databases in an attempt

7535 to ascertain the identity of the deceased person.

7536 (2) A county which has received a body to which Subsection (1) applies:

7537 (a) shall adopt and use the same identifying number assigned by Subsection (1) in all
7538 records created by the county that pertain to the body;

7539 (b) require any funeral director or sexton who is involved in the disposition of the body
7540 to adopt and use the same identifying number assigned by Subsection (1) in all records created
7541 by the funeral director or sexton pertaining to the body; and

7542 (c) shall provide a decent burial for the body.

7543 (3) Within 30 days of receiving a body to which Subsection (1) applies, the county
7544 shall inform the medical examiner of the disposition of the body including the burial plot. The
7545 medical examiner shall record this information in the file created and maintained under
7546 Subsection (1)(b).

7547 (4) The requirements of Subsections (1) and (6) apply to a county examiner appointed
7548 under Section [~~26-4-5~~] [26B-8-203](#), with the additional requirements that the county examiner:

7549 (a) obtain a unique identifying number from the medical examiner for the body; and

7550 (b) send to the medical examiner a copy of the file created and maintained in
7551 accordance with Subsection (1)(b), including the disposition of the body and burial plot, within
7552 30 days of releasing the body.

7553 (5) The medical examiner shall maintain a file received under Subsection (4) in the
7554 same way that it maintains a file created and maintained by the medical examiner in accordance
7555 with Subsection (1)(b).

7556 (6) The medical examiner shall cooperate and share information generated and
7557 maintained under this section with a person who demonstrates:

7558 (a) a legitimate personal or governmental interest in determining the identity of a
7559 deceased person; and

7560 (b) a reasonable belief that the body of that deceased person may have come into the
7561 custody of the medical examiner.

7562 Section 237. Section **26B-8-228**, which is renumbered from Section 26-4-28 is
7563 renumbered and amended to read:

7564 ~~[26-4-28]~~. **26B-8-228**. **Testing for suspected suicides -- Maintaining**
7565 **information -- Compensation to deputy medical examiners.**

7566 (1) In all cases where it is suspected that a death resulted from suicide, including
7567 assisted suicide, the medical examiner shall endeavor to have the following tests conducted
7568 upon samples taken from the body of the deceased:

7569 (a) a test that detects all of the substances included in the volatiles panel of the Bureau
7570 of Forensic Toxicology within the ~~[Department of Health]~~ department;

7571 (b) a test that detects all of the substances included in the drugs of abuse panel of the
7572 Bureau of Forensic Toxicology within the ~~[Department of Health]~~ department; and

7573 (c) a test that detects all of the substances included in the prescription drug panel of the
7574 Bureau of Forensic Toxicology within the ~~[Department of Health]~~ department.

7575 (2) The medical examiner shall maintain information regarding the types of substances
7576 found present in the samples taken from the body of a person who is suspected to have died as
7577 a result of suicide or assisted suicide.

7578 (3) Within funds appropriated by the Legislature for this purpose, the medical
7579 examiner shall provide compensation, at a standard rate determined by the medical examiner,
7580 to a deputy medical examiner who collects samples for the purposes described in Subsection
7581 (1).

7582 Section 238. Section **26B-8-229**, which is renumbered from Section 26-4-28.5 is
7583 renumbered and amended to read:

7584 ~~[26-4-28.5]~~. **26B-8-229**. **Psychological autopsy examiner.**

7585 (1) With funds appropriated by the Legislature for this purpose, the department shall
7586 provide compensation, at a standard rate determined by the department, to a psychological
7587 autopsy examiner.

7588 (2) The psychological autopsy examiner shall:

7589 (a) work with the medical examiner to compile data regarding suicide related deaths;

7590 (b) as relatives of the deceased are willing, gather information from relatives of the
7591 deceased regarding the psychological reasons for the decedent's death;

7592 (c) maintain a database of information described in Subsections (2)(a) and (b);

7593 (d) in accordance with all applicable privacy laws subject to approval by the
7594 department, share the database described in Subsection (2)(c) with the University of Utah
7595 Department of Psychiatry or other university-based departments conducting research on
7596 suicide;

7597 (e) coordinate no less than monthly with the suicide prevention coordinator described
7598 in Subsection [~~62A-15-1101~~] 26B-5-611(2); and

7599 (f) coordinate no less than quarterly with the state suicide prevention coalition.

7600 Section 239. Section **26B-8-230**, which is renumbered from Section 26-4-29 is
7601 renumbered and amended to read:

7602 ~~[26-4-29]~~. **26B-8-230**. **Application for permit to render a dead body**
7603 **unavailable for postmortem examination -- Fees.**

7604 (1) Upon receiving an application by a person for a permit to render a dead body
7605 unavailable for postmortem investigation, the medical examiner shall review the application to
7606 determine whether:

7607 (a) the person is authorized by law to render the dead body unavailable for postmortem
7608 investigation in the manner specified in the application; and

7609 (b) there is a need to delay any action that will render the dead body unavailable for
7610 postmortem investigation until a postmortem investigation or an autopsy of the dead body is
7611 performed by the medical examiner.

7612 (2) Except as provided in Subsection (4), within three days after receiving an
7613 application described in Subsection (1), the medical examiner shall:

7614 (a) make the determinations described in Subsection (1); and

7615 (b) (i) issue a permit to render the dead body unavailable for postmortem investigation

7616 in the manner specified in the application; or

7617 (ii) deny the permit.

7618 (3) The medical examiner may deny a permit to render a dead body unavailable for
7619 postmortem investigation only if:

7620 (a) the applicant is not authorized by law to render the dead body unavailable for
7621 postmortem investigation in the manner specified in the application;

7622 (b) the medical examiner determines that there is a need to delay any action that will
7623 render the dead body unavailable for postmortem investigation; or

7624 (c) the applicant fails to pay the fee described in Subsection (5).

7625 (4) If the medical examiner cannot in good faith make the determinations described in
7626 Subsection (1) within three days after receiving an application described in Subsection (1), the
7627 medical examiner shall notify the applicant:

7628 (a) that more time is needed to make the determinations described in Subsection (1);
7629 and

7630 (b) of the estimated amount of time needed before the determinations described in
7631 Subsection (1) can be made.

7632 (5) The medical examiner may charge a fee, pursuant to Section [63J-1-504](#), to recover
7633 the costs of fulfilling the duties of the medical examiner described in this section.

7634 Section 240. Section **26B-8-231**, which is renumbered from Section 26-4-30 is
7635 renumbered and amended to read:

7636 ~~[26-4-30]~~. **26B-8-231. Overdose fatality examiner.**

7637 (1) Within funds appropriated by the Legislature, the department shall provide
7638 compensation, at a standard rate determined by the department, to an overdose fatality
7639 examiner.

7640 (2) The overdose fatality examiner shall:

7641 (a) work with the medical examiner to compile data regarding overdose and opioid
7642 related deaths, including:

- 7643 (i) toxicology information;
- 7644 (ii) demographics; and
- 7645 (iii) the source of opioids or drugs;
- 7646 (b) as relatives of the deceased are willing, gather information from relatives of the
- 7647 deceased regarding the circumstances of the decedent's death;
- 7648 (c) maintain a database of information described in Subsections (2)(a) and (b);
- 7649 (d) coordinate no less than monthly with the suicide prevention coordinator described
- 7650 in Section [~~62A-15-1101~~] 26B-5-611; and
- 7651 (e) coordinate no less than quarterly with the Opioid and Overdose Fatality Review
- 7652 Committee created in Section [~~26-7-13~~] 26B-1-403.

7653 Section 241. Section **26B-8-232**, which is renumbered from Section 26-23a-2 is

7654 renumbered and amended to read:

7655 ~~[26-23a-2]~~. **26B-8-232. Injury reporting requirements by health care provider**

7656 **-- Contents of report -- Penalties.**

7657 (1) As used in this section:

7658 (a) "Health care provider" means any person, firm, corporation, or association which

7659 furnishes treatment or care to persons who have suffered bodily injury, and includes hospitals,

7660 clinics, podiatrists, dentists and dental hygienists, nurses, nurse practitioners, physicians and

7661 physicians' assistants, osteopathic physicians, naturopathic practitioners, chiropractors,

7662 acupuncturists, paramedics, and emergency medical technicians.

7663 (b) "Injury" does not include any psychological or physical condition brought about

7664 solely through the voluntary administration of prescribed controlled substances.

7665 (c) "Law enforcement agency" means the municipal or county law enforcement agency:

7666 (i) having jurisdiction over the location where the injury occurred; or

7667 (ii) if the reporting health care provider is unable to identify or contact the law

7668 enforcement agency with jurisdiction over the injury, "law enforcement agency" means the

7669 agency nearest to the location of the reporting health care provider.

7670 (d) "Report to a law enforcement agency" means to report, by telephone or other
 7671 spoken communication, the facts known regarding an injury subject to reporting under Section
 7672 26-23a-2 to the dispatch desk or other staff person designated by the law enforcement agency
 7673 to receive reports from the public.

7674 [(1)] (2) (a) Any health care provider who treats or cares for any person who suffers
 7675 from any wound or other injury inflicted by the person's own act or by the act of another by
 7676 means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of
 7677 any criminal statute of this state, shall immediately report to a law enforcement agency the facts
 7678 regarding the injury.

7679 (b) The report shall state the name and address of the injured person, if known, the
 7680 person's whereabouts, the character and extent of the person's injuries, and the name, address,
 7681 and telephone number of the person making the report.

7682 [(2)] (3) A health care provider may not be discharged, suspended, disciplined, or
 7683 harassed for making a report pursuant to this section.

7684 [(3)] (4) A person may not incur any civil or criminal liability as a result of making any
 7685 report required by this section.

7686 [(4)] (5) A health care provider who has personal knowledge that the report of a wound
 7687 or injury has been made in compliance with this section is under no further obligation to make
 7688 a report regarding that wound or injury under this section.

7689 (6) Any health care provider who intentionally or knowingly violates any provision of
 7690 this section is guilty of a class B misdemeanor.

7691 Section 242. Section **26B-8-301**, which is renumbered from Section 26-28-102 is
 7692 renumbered and amended to read:

Part 3. Revised Uniform Anatomical Gift Act

~~[26-28-102]~~. **26B-8-301. Definitions.**

As used in this [chapter] part:

(1) "Adult" means an individual who is at least 18 years [~~of age~~] old.

- 7697 (2) "Agent" means an individual:
- 7698 (a) authorized to make health care decisions on the principal's behalf by a power of
- 7699 attorney for health care; or
- 7700 (b) expressly authorized to make an anatomical gift on the principal's behalf by any
- 7701 other record signed by the principal.
- 7702 (3) "Anatomical gift" means a donation of all or part of a human body to take effect
- 7703 after the donor's death for the purpose of transplantation, therapy, research, or education.
- 7704 (4) "Decedent" means:
- 7705 (a) a deceased individual whose body or part is or may be the source of an anatomical
- 7706 gift; and
- 7707 (b) includes:
- 7708 (i) a stillborn infant; and
- 7709 (ii) subject to restrictions imposed by law other than this ~~[chapter]~~ part, a fetus.
- 7710 (5) (a) "Disinterested witness" means:
- 7711 (i) a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or
- 7712 guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift;
- 7713 or
- 7714 (ii) another adult who exhibited special care and concern for the individual.
- 7715 (b) "Disinterested witness" does not include a person to which an anatomical gift could
- 7716 pass under Section ~~[26-28-111]~~ 26B-8-310.
- 7717 (6) "Document of gift" means a donor card or other record used to make an anatomical
- 7718 gift. The term includes a statement or symbol on a driver license, identification card, or donor
- 7719 registry.
- 7720 (7) "Donor" means an individual whose body or part is the subject of an anatomical
- 7721 gift.
- 7722 (8) "Donor registry" means a database that contains records of anatomical gifts and
- 7723 amendments to or revocations of anatomical gifts.

7724 (9) "Driver license" means a license or permit issued by the Driver License Division of
7725 the Department of Public Safety, to operate a vehicle, whether or not conditions are attached to
7726 the license or permit.

7727 (10) "Eye bank" means a person that is licensed, accredited, or regulated under federal
7728 or state law to engage in the recovery, screening, testing, processing, storage, or distribution of
7729 human eyes or portions of human eyes.

7730 (11) "Guardian":

7731 (a) means a person appointed by a court to make decisions regarding the support, care,
7732 education, health, or welfare of an individual; and

7733 (b) does not include a guardian ad litem.

7734 (12) "Hospital" means a facility licensed as a hospital under the law of any state or a
7735 facility operated as a hospital by the United States, a state, or a subdivision of a state.

7736 (13) "Identification card" means an identification card issued by the Driver License
7737 Division of the Department of Public Safety.

7738 (14) "Know" means to have actual knowledge.

7739 (15) "Minor" means an individual who is under 18 years of age.

7740 (16) "Organ procurement organization" means a person designated by the Secretary of
7741 the United States Department of Health and Human Services as an organ procurement
7742 organization.

7743 (17) "Parent" means a parent whose parental rights have not been terminated.

7744 (18) "Part" means an organ, an eye, or tissue of a human being. The term does not
7745 include the whole body.

7746 (19) "Person" means an individual, corporation, business trust, estate, trust,
7747 partnership, limited liability company, association, joint venture, public corporation,
7748 government or governmental subdivision, agency, or instrumentality, or any other legal or
7749 commercial entity.

7750 (20) "Physician" means an individual authorized to practice medicine or osteopathy

7751 under the law of any state.

7752 (21) "Procurement organization" means an eye bank, organ procurement organization,
7753 or tissue bank.

7754 (22) "Prospective donor":

7755 (a) means an individual who is dead or near death and has been determined by a
7756 procurement organization to have a part that could be medically suitable for transplantation,
7757 therapy, research, or education; and

7758 (b) does not include an individual who has made a refusal.

7759 (23) "Reasonably available" means able to be contacted by a procurement organization
7760 without undue effort and willing and able to act in a timely manner consistent with existing
7761 medical criteria necessary for the making of an anatomical gift.

7762 (24) "Recipient" means an individual into whose body a decedent's part has been or is
7763 intended to be transplanted.

7764 (25) "Record" means information that is inscribed on a tangible medium or that is
7765 stored in an electronic or other medium and is retrievable in perceivable form.

7766 (26) "Refusal" means a record created under Section [~~26-28-107~~] [26B-8-306](#) that
7767 expressly states an intent to bar other persons from making an anatomical gift of an individual's
7768 body or part.

7769 (27) "Sign" means, with the present intent to authenticate or adopt a record:

7770 (a) to execute or adopt a tangible symbol; or

7771 (b) to attach to or logically associate with the record an electronic symbol, sound, or
7772 process.

7773 (28) "State" means a state of the United States, the District of Columbia, Puerto Rico,
7774 the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction
7775 of the United States.

7776 (29) "Technician":

7777 (a) means an individual determined to be qualified to remove or process parts by an

7778 appropriate organization that is licensed, accredited, or regulated under federal or state law; and

7779 (b) includes an enucleator.

7780 (30) "Tissue" means a portion of the human body other than an organ or an eye. The

7781 term does not include blood unless the blood is donated for the purpose of research or

7782 education.

7783 (31) "Tissue bank" means a person that is licensed, accredited, or regulated under

7784 federal or state law to engage in the recovery, screening, testing, processing, storage, or

7785 distribution of tissue.

7786 (32) "Transplant hospital" means a hospital that furnishes organ transplants and other

7787 medical and surgical specialty services required for the care of transplant patients.

7788 Section 243. Section **26B-8-302**, which is renumbered from Section 26-28-103 is

7789 renumbered and amended to read:

7790 ~~[26-28-103]~~. **26B-8-302. Applicability.**

7791 This ~~[chapter]~~ part applies to an anatomical gift or amendment to, revocation of, or

7792 refusal to make an anatomical gift, whenever made.

7793 Section 244. Section **26B-8-303**, which is renumbered from Section 26-28-104 is

7794 renumbered and amended to read:

7795 ~~[26-28-104]~~. **26B-8-303. Who may make anatomical gift before donor's**

7796 **death.**

7797 Subject to Section ~~[26-28-108]~~ 26B-8-307, an anatomical gift of a donor's body or part

7798 may be made during the life of the donor for the purpose of transplantation, therapy, research,

7799 or education in the manner provided in Section ~~[26-28-105]~~ 26B-8-304 by:

7800 (1) the donor, if the donor is an adult or if the donor is a minor and is:

7801 (a) emancipated; or

7802 (b) authorized under state law to apply for a driver license because the donor is at least

7803 15 years ~~[of age]~~ old;

7804 (2) an agent of the donor, unless the power of attorney for health care or other record

7805 prohibits the agent from making an anatomical gift;

7806 (3) a parent of the donor, if the donor is an unemancipated minor; or

7807 (4) the donor's guardian.

7808 Section 245. Section **26B-8-304**, which is renumbered from Section 26-28-105 is

7809 renumbered and amended to read:

7810 ~~[26-28-105]~~. **26B-8-304**. **Manner of making anatomical gift before donor's**

7811 **death.**

7812 (1) A donor may make an anatomical gift:

7813 (a) by authorizing a statement or symbol indicating that the donor has made an

7814 anatomical gift to be imprinted on the donor's driver license or identification card;

7815 (b) in a will;

7816 (c) during a terminal illness or injury of the donor, by any form of communication

7817 addressed to at least two adults, at least one of whom is a disinterested witness; or

7818 (d) as provided in Subsection (2).

7819 (2) A donor or other person authorized to make an anatomical gift under Section

7820 ~~[26-28-104]~~ 26B-8-303 may make a gift by a donor card or other record signed by the donor or

7821 other person making the gift or by authorizing that a statement or symbol indicating that the

7822 donor has made an anatomical gift be included on a donor registry. If the donor or other person

7823 is physically unable to sign a record, the record may be signed by another individual at the

7824 direction of the donor or other person and shall:

7825 (a) be witnessed by at least two adults, at least one of whom is a disinterested witness,

7826 who have signed at the request of the donor or the other person; and

7827 (b) state that it has been signed and witnessed as provided in Subsection (2)(a).

7828 (3) Revocation, suspension, expiration, or cancellation of a driver license or

7829 identification card upon which an anatomical gift is indicated does not invalidate the gift.

7830 (4) An anatomical gift made by will takes effect upon the donor's death whether or not

7831 the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

7832 Section 246. Section **26B-8-305**, which is renumbered from Section 26-28-106 is
7833 renumbered and amended to read:

7834 ~~[26-28-106]~~. **26B-8-305**. **Amending or revoking anatomical gift before**
7835 **donor's death.**

7836 (1) Subject to Section ~~[26-28-108]~~ 26B-8-307, a donor or other person authorized to
7837 make an anatomical gift under Section ~~[26-28-104]~~ 26B-8-303 may amend or revoke an
7838 anatomical gift by:

7839 (a) a record signed by:

7840 (i) the donor;

7841 (ii) the other person; or

7842 (iii) subject to Subsection (2), another individual acting at the direction of the donor or
7843 the other person if the donor or other person is physically unable to sign; or

7844 (b) a later-executed document of gift that amends or revokes a previous anatomical gift
7845 or portion of an anatomical gift, either expressly or by inconsistency.

7846 (2) A record signed pursuant to Subsection (1)(a)(iii) shall:

7847 (a) be witnessed by at least two adults, at least one of whom is a disinterested witness,
7848 who have signed at the request of the donor or the other person; and

7849 (b) state that it has been signed and witnessed as provided in Subsection (1)(a).

7850 (3) Subject to Section ~~[26-28-108]~~ 26B-8-307, a donor or other person authorized to
7851 make an anatomical gift under Section ~~[26-28-104]~~ 26B-8-303 may revoke an anatomical gift
7852 by the destruction or cancellation of the document of gift, or the portion of the document of gift
7853 used to make the gift, with the intent to revoke the gift.

7854 (4) A donor may amend or revoke an anatomical gift that was not made in a will by any
7855 form of communication during a terminal illness or injury addressed to at least two adults, at
7856 least one of whom is a disinterested witness.

7857 (5) A donor who makes an anatomical gift in a will may amend or revoke the gift in the
7858 manner provided for amendment or revocation of wills or as provided in Subsection (1).

7859 Section 247. Section **26B-8-306**, which is renumbered from Section 26-28-107 is
7860 renumbered and amended to read:

7861 ~~[26-28-107]~~. **26B-8-306. Refusal to make anatomical gift -- Effect of**
7862 **refusal.**

7863 (1) An individual may refuse to make an anatomical gift of the individual's body or part
7864 by:

7865 (a) a record signed by:

7866 (i) the individual; or

7867 (ii) subject to Subsection (2), another individual acting at the direction of the individual
7868 if the individual is physically unable to sign;

7869 (b) the individual's will, whether or not the will is admitted to probate or invalidated
7870 after the individual's death; or

7871 (c) any form of communication made by the individual during the individual's terminal
7872 illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

7873 (2) A record signed pursuant to Subsection (1)(a)(ii) shall:

7874 (a) be witnessed by at least two adults, at least one of whom is a disinterested witness,
7875 who have signed at the request of the individual; and

7876 (b) state that it has been signed and witnessed as provided in Subsection (1)(a).

7877 (3) An individual who has made a refusal may amend or revoke the refusal:

7878 (a) in the manner provided in Subsection (1) for making a refusal;

7879 (b) by subsequently making an anatomical gift pursuant to Section ~~[26-28-105]~~

7880 26B-8-304 that is inconsistent with the refusal; or

7881 (c) by destroying or canceling the record evidencing the refusal, or the portion of the
7882 record used to make the refusal, with the intent to revoke the refusal.

7883 (4) Except as otherwise provided in Subsection ~~[26-28-108]~~ 26B-8-307(8), in the

7884 absence of an express, contrary indication by the individual set forth in the refusal, an

7885 individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars

7886 all other persons from making an anatomical gift of the individual's body or part.

7887 Section 248. Section **26B-8-307**, which is renumbered from Section 26-28-108 is
7888 renumbered and amended to read:

7889 ~~[26-28-108]~~. **26B-8-307**. **Preclusive effect of anatomical gift, amendment,**
7890 **or revocation.**

7891 (1) Except as otherwise provided in Subsection (7) and subject to Subsection (6), in the
7892 absence of an express, contrary indication by the donor, a person other than the donor is barred
7893 from making, amending, or revoking an anatomical gift of a donor's body or part if the donor
7894 made an anatomical gift of the donor's body or part under Section ~~[26-28-105]~~ 26B-8-304 or an
7895 amendment to an anatomical gift of the donor's body or part under Section ~~[26-28-106]~~
7896 26B-8-305.

7897 (2) A donor's revocation of an anatomical gift of the donor's body or part under Section
7898 ~~[26-28-106]~~ 26B-8-305 is not a refusal and does not bar another person specified in Section
7899 ~~[26-28-104 or 26-28-109]~~ 26B-8-303 or 26B-8-308 from making an anatomical gift of the
7900 donor's body or part under Section ~~[26-28-105 or 26-28-110]~~ 26B-8-304 or 26B-8-309.

7901 (3) If a person other than the donor makes an unrevoked anatomical gift of the donor's
7902 body or part under Section ~~[26-28-105]~~ 26B-8-304 or an amendment to an anatomical gift of
7903 the donor's body or part under Section ~~[26-28-106]~~ 26B-8-305, another person may not make,
7904 amend, or revoke the gift of the donor's body or part under Section ~~[26-28-110]~~ 26B-8-309.

7905 (4) A revocation of an anatomical gift of a donor's body or part under Section
7906 ~~[26-28-106]~~ 26B-8-305 by a person other than the donor does not bar another person from
7907 making an anatomical gift of the body or part under Section ~~[26-28-105 or 26-28-110]~~
7908 26B-8-304 or 26B-8-309.

7909 (5) In the absence of an express, contrary indication by the donor or other person
7910 authorized to make an anatomical gift under Section ~~[26-28-104]~~ 26B-8-303, an anatomical
7911 gift of a part is neither a refusal to give another part nor a limitation on the making of an
7912 anatomical gift of another part at a later time by the donor or another person.

7913 (6) In the absence of an express, contrary indication by the donor or other person
7914 authorized to make an anatomical gift under Section [~~26-28-104~~] 26B-8-303, an anatomical
7915 gift of a part for one or more of the purposes set forth in Section [~~26-28-104~~] 26B-8-303 is not
7916 a limitation on the making of an anatomical gift of the part for any of the other purposes by the
7917 donor or any other person under Section [~~26-28-105 or 26-28-110~~] 26B-8-304 or 26B-8-309.

7918 (7) If a donor who is an unemancipated minor dies, a parent of the donor who is
7919 reasonably available may revoke or amend an anatomical gift of the donor's body or part.

7920 (8) If an unemancipated minor who signed a refusal dies, a parent of the minor who is
7921 reasonably available may revoke the minor's refusal.

7922 Section 249. Section **26B-8-308**, which is renumbered from Section 26-28-109 is
7923 renumbered and amended to read:

7924 [~~26-28-109~~]. **26B-8-308. Who may make anatomical gift of decedent's**
7925 **body or part.**

7926 (1) Subject to Subsections (2) and (3) and unless barred by Section [~~26-28-107 or~~
7927 ~~26-28-108~~] 26B-8-306 or 26B-8-307, an anatomical gift of a decedent's body or part for
7928 purpose of transplantation, therapy, research, or education may be made by any member of the
7929 following classes of persons who is reasonably available, in the order of priority listed:

7930 (a) an agent of the decedent at the time of death who could have made an anatomical
7931 gift under Subsection [~~26-28-104~~] 26B-8-303(2) immediately before the decedent's death;

7932 (b) the spouse of the decedent;

7933 (c) adult children of the decedent;

7934 (d) parents of the decedent;

7935 (e) adult siblings of the decedent;

7936 (f) adult grandchildren of the decedent;

7937 (g) grandparents of the decedent;

7938 (h) the persons who were acting as the guardians of the person of the decedent at the
7939 time of death;

7940 (i) an adult who exhibited special care and concern for the decedent; and
7941 (j) any other person having the authority to dispose of the decedent's body.
7942 (2) If there is more than one member of a class listed in Subsection (1)(a), (c), (d), (e),
7943 (f), (g), or (j) entitled to make an anatomical gift, an anatomical gift may be made by a member
7944 of the class unless that member or a person to which the gift may pass under Section
7945 ~~[26-28-111]~~ [26B-8-310](#) knows of an objection by another member of the class. If an objection
7946 is known, the gift may be made only by a majority of the members of the class who are
7947 reasonably available.

7948 (3) A person may not make an anatomical gift if, at the time of the decedent's death, a
7949 person in a prior class under Subsection (1) is reasonably available to make or to object to the
7950 making of an anatomical gift.

7951 Section 250. Section **26B-8-309**, which is renumbered from Section 26-28-110 is
7952 renumbered and amended to read:

7953 ~~[26-28-110]~~. **26B-8-309. Manner of making, amending, or revoking**
7954 **anatomical gift of decedent's body or part.**

7955 (1) A person authorized to make an anatomical gift under Section ~~[26-28-109]~~
7956 [26B-8-308](#) may make an anatomical gift by a document of gift signed by the person making the
7957 gift or by that person's oral communication that is electronically recorded or is
7958 contemporaneously reduced to a record and signed by the individual receiving the oral
7959 communication.

7960 (2) Subject to Subsection (3), an anatomical gift by a person authorized under Section
7961 ~~[26-28-109]~~ [26B-8-308](#) may be amended or revoked orally or in a record by any member of a
7962 prior class who is reasonably available. If more than one member of the prior class is
7963 reasonably available, the gift made by a person authorized under Section ~~[26-28-109]~~
7964 [26B-8-308](#) may be:

7965 (a) amended only if a majority of the reasonably available members agree to the
7966 amending of the gift; or

7967 (b) revoked only if a majority of the reasonably available members agree to the
7968 revoking of the gift or if they are equally divided as to whether to revoke the gift.

7969 (3) A revocation under Subsection (2) is effective only if, before an incision has been
7970 made to remove a part from the donor's body or before invasive procedures have begun to
7971 prepare the recipient, the procurement organization, transplant hospital, or physician or
7972 technician knows of the revocation.

7973 Section 251. Section **26B-8-310**, which is renumbered from Section 26-28-111 is
7974 renumbered and amended to read:

7975 ~~[26-28-111]~~. **26B-8-310**. **Persons that may receive anatomical gift --**
7976 **Purpose of anatomical gift.**

7977 (1) An anatomical gift may be made to the following persons named in the document
7978 of gift:

7979 (a) a hospital, accredited medical school, dental school, college, university, organ
7980 procurement organization, or other appropriate person, for research or education;

7981 (b) subject to Subsection (2), an individual designated by the person making the
7982 anatomical gift if the individual is the recipient of the part; or

7983 (c) an eye bank or tissue bank.

7984 (2) If an anatomical gift to an individual under Subsection (1)(b) cannot be
7985 transplanted into the individual, the part passes in accordance with Subsection (7) in the
7986 absence of an express, contrary indication by the person making the anatomical gift.

7987 (3) If an anatomical gift of one or more specific parts or of all parts is made in a
7988 document of gift that does not name a person described in Subsection (1) but identifies the
7989 purpose for which an anatomical gift may be used, the following rules apply:

7990 (a) If the part is an eye and the gift is for the purpose of transplantation or therapy, the
7991 gift passes to the appropriate eye bank.

7992 (b) If the part is tissue and the gift is for the purpose of transplantation or therapy, the
7993 gift passes to the appropriate tissue bank.

7994 (c) If the part is an organ and the gift is for the purpose of transplantation or therapy,
7995 the gift passes to the appropriate organ procurement organization as custodian of the organ.

7996 (d) If the part is an organ, an eye, or tissue and the gift is for the purpose of research or
7997 education, the gift passes to the appropriate procurement organization.

7998 (4) For the purpose of Subsection (3), if there is more than one purpose of an
7999 anatomical gift set forth in the document of gift but the purposes are not set forth in any
8000 priority, the gift shall be used for transplantation or therapy, if suitable. If the gift cannot be
8001 used for transplantation or therapy, the gift may be used for research or education.

8002 (5) If an anatomical gift of one or more specific parts is made in a document of gift that
8003 does not name a person described in Subsection (1) and does not identify the purpose of the
8004 gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance
8005 with Subsection (7).

8006 (6) If a document of gift specifies only a general intent to make an anatomical gift by
8007 words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar
8008 import, the gift may be used only for transplantation or therapy, and the gift passes in
8009 accordance with Subsection (7).

8010 (7) For purposes of Subsections (2), (5), and this Subsection (7), the following rules
8011 apply:

8012 (a) If the part is an eye, the gift passes to the appropriate eye bank.

8013 (b) If the part is tissue, the gift passes to the appropriate tissue bank.

8014 (c) If the part is an organ, the gift passes to the appropriate organ procurement
8015 organization as custodian of the organ.

8016 (8) An anatomical gift of an organ for transplantation or therapy, other than an
8017 anatomical gift under Subsection (1)(b), passes to the organ procurement organization as
8018 custodian of the organ.

8019 (9) If an anatomical gift does not pass pursuant to Subsections (2) through (8) or the
8020 decedent's body or part is not used for transplantation, therapy, research, or education, custody

8021 of the body or part passes to the person under obligation to dispose of the body or part.

8022 (10) A person may not accept an anatomical gift if the person knows that the gift was
8023 not effectively made under Section [~~26-28-105 or 26-28-110~~] 26B-8-304 or 26B-8-309 or if the
8024 person knows that the decedent made a refusal under Section [~~26-28-107~~] 26B-8-306 that was
8025 not revoked. For purposes of this Subsection (10), if a person knows that an anatomical gift
8026 was made on a document of gift, the person is considered to know of any amendment or
8027 revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

8028 (11) Except as otherwise provided in Subsection (1)(b), nothing in this [~~chapter~~] part
8029 affects the allocation of organs for transplantation or therapy.

8030 Section 252. Section **26B-8-311**, which is renumbered from Section 26-28-112 is
8031 renumbered and amended to read:

8032 [~~26-28-112~~]. **26B-8-311. Search and notification.**

8033 (1) The following persons shall make a reasonable search of an individual who the
8034 person reasonably believes is dead or near death for a document of gift or other information
8035 identifying the individual as a donor or as an individual who made a refusal:

8036 (a) a law enforcement officer, firefighter, paramedic, or other emergency rescuer
8037 finding the individual;

8038 (b) if no other source of the information is immediately available, a hospital, as soon as
8039 practical after the individual's arrival at the hospital; and

8040 (c) a law enforcement officer, firefighter, emergency medical services provider, or
8041 other emergency rescuer who finds an individual who is deceased at the scene of a motor
8042 vehicle accident, when the deceased individual is transported from the scene of the accident to
8043 a funeral establishment licensed under Title 58, Chapter 9, Funeral Services Licensing Act:

8044 (i) the law enforcement officer, firefighter, emergency medical services provider, or
8045 other emergency rescuer shall as soon as reasonably possible, notify the appropriate organ
8046 procurement organization, tissue bank, or eye bank of:

8047 (A) the identity of the deceased individual, if known;

8048 (B) information, if known, pertaining to the deceased individual's legal next-of-kin in
8049 accordance with Section [~~26-28-109~~] [26B-8-308](#); and

8050 (C) the name and location of the funeral establishment which received custody of and
8051 transported the deceased individual; and

8052 (ii) the funeral establishment receiving custody of the deceased individual under this
8053 Subsection (1)(c) may not embalm the body of the deceased individual until:

8054 (A) the funeral establishment receives notice from the organ procurement organization,
8055 tissue bank, or eye bank that the readily available persons listed as having priority in Section
8056 [~~26-28-109~~] [26B-8-308](#) have been informed by the organ procurement organization of the
8057 option to make or refuse to make an anatomical gift in accordance with Section [~~26-28-104~~]
8058 [26B-8-303](#), with reasonable discretion and sensitivity appropriate to the circumstances of the
8059 family;

8060 (B) in accordance with federal law, prior approval for embalming has been obtained
8061 from a family member or other authorized person; and

8062 (C) the period of time in which embalming is prohibited under Subsection (1)(c)(ii)
8063 may not exceed 24 hours after death.

8064 (2) If a document of gift or a refusal to make an anatomical gift is located by the search
8065 required by Subsection (1)(a) and the individual or deceased individual to whom it relates is
8066 taken to a hospital, the person responsible for conducting the search shall send the document of
8067 gift or refusal to the hospital.

8068 (3) A person is not subject to criminal or civil liability for failing to discharge the
8069 duties imposed by this section but may be subject to administrative sanctions.

8070 Section 253. Section **26B-8-312**, which is renumbered from Section 26-28-113 is
8071 renumbered and amended to read:

8072 [~~26-28-113~~]. **26B-8-312. Delivery of document of gift not required -- Right**
8073 **to examine.**

8074 (1) A document of gift need not be delivered during the donor's lifetime to be effective.

8075 (2) Upon or after an individual's death, a person in possession of a document of gift or
8076 a refusal to make an anatomical gift with respect to the individual shall allow examination and
8077 copying of the document of gift or refusal by a person authorized to make or object to the
8078 making of an anatomical gift with respect to the individual or by a person to which the gift
8079 could pass under Section [~~26-28-114~~] [26B-8-310](#).

8080 Section 254. Section **26B-8-313**, which is renumbered from Section 26-28-114 is
8081 renumbered and amended to read:

8082 [~~26-28-114~~]. **26B-8-313. Rights and duties of procurement organization**
8083 **and others.**

8084 (1) When a hospital refers an individual at or near death to a procurement organization,
8085 the organization shall make a reasonable search of the records of the Department of Public
8086 Safety and any donor registry that it knows exists for the geographical area in which the
8087 individual resides to ascertain whether the individual has made an anatomical gift.

8088 (2) A procurement organization shall be allowed reasonable access to information in
8089 the records of the Department of Public Safety to ascertain whether an individual at or near
8090 death is a donor.

8091 (3) When a hospital refers an individual at or near death to a procurement organization,
8092 the organization may conduct any reasonable examination necessary to ensure the medical
8093 suitability of a part that is or could be the subject of an anatomical gift for transplantation,
8094 therapy, research, or education from a donor or a prospective donor. During the examination
8095 period, measures necessary to ensure the medical suitability of the part may not be withdrawn
8096 unless the hospital or procurement organization knows that the individual expressed a contrary
8097 intent.

8098 (4) Unless prohibited by law other than this [~~chapter~~] part, at any time after a donor's
8099 death, the person to which a part passes under Section [~~26-28-114~~] [26B-8-310](#) may conduct
8100 any reasonable examination necessary to ensure the medical suitability of the body or part for
8101 its intended purpose.

8102 (5) Unless prohibited by law other than this ~~[chapter]~~ part, an examination under
8103 Subsection (3) or (4) may include an examination of all medical and dental records of the
8104 donor or prospective donor.

8105 (6) Upon the death of a minor who was a donor or had signed a refusal, unless a
8106 procurement organization knows the minor is emancipated, the procurement organization shall
8107 conduct a reasonable search for the parents of the minor and provide the parents with an
8108 opportunity to revoke or amend the anatomical gift or revoke the refusal.

8109 (7) Upon referral by a hospital under Subsection (1), a procurement organization shall
8110 make a reasonable search for any person listed in Section ~~[26-28-109]~~ 26B-8-308 having
8111 priority to make an anatomical gift on behalf of a prospective donor. If a procurement
8112 organization receives information that an anatomical gift to any other person was made,
8113 amended, or revoked, it shall promptly advise the other person of all relevant information.

8114 (8) Subject to Subsection ~~[26-28-111]~~ 26B-8-310(9) and Section ~~[26-28-123]~~
8115 26B-8-322, the rights of the person to which a part passes under Section ~~[26-28-111]~~
8116 26B-8-310 are superior to the rights of all others with respect to the part. The person may
8117 accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of
8118 gift and this ~~[chapter]~~ part, a person that accepts an anatomical gift of an entire body may allow
8119 embalming, burial or cremation, and use of remains in a funeral service. If the gift is of a part,
8120 the person to which the part passes under Section ~~[26-28-111]~~ 26B-8-310, upon the death of
8121 the donor and before embalming, burial, or cremation, shall cause the part to be removed
8122 without unnecessary mutilation.

8123 (9) Neither the physician or physician assistant who attends the decedent at death nor
8124 the physician or physician assistant who determines the time of the decedent's death may
8125 participate in the procedures for removing or transplanting a part from the decedent.

8126 (10) A physician, physician assistant, or technician may remove a donated part from
8127 the body of a donor that the physician, physician assistant, or technician is qualified to remove.

8128 Section 255. Section **26B-8-314**, which is renumbered from Section 26-28-115 is

8129 renumbered and amended to read:

8130 ~~[26-28-115]~~. **26B-8-314. Coordination of procurement and use.**

8131 Each hospital in this state shall enter into agreements or affiliations with procurement
8132 organizations for coordination of procurement and use of anatomical gifts.

8133 Section 256. Section **26B-8-315**, which is renumbered from Section 26-28-116 is
8134 renumbered and amended to read:

8135 ~~[26-28-116]~~. **26B-8-315. Sale or purchase of parts prohibited.**

8136 (1) Except as otherwise provided in Subsection (2), a person that for valuable
8137 consideration, knowingly purchases or sells a part for transplantation or therapy if removal of a
8138 part from an individual is intended to occur after the individual's death commits a third degree
8139 felony.

8140 (2) A person may charge a reasonable amount for the removal, processing,
8141 preservation, quality control, storage, transportation, implantation, or disposal of a part.

8142 Section 257. Section **26B-8-316**, which is renumbered from Section 26-28-117 is
8143 renumbered and amended to read:

8144 ~~[26-28-117]~~. **26B-8-316. Other prohibited acts.**

8145 A person that, in order to obtain a financial gain, intentionally falsifies, forges,
8146 conceals, defaces, or obliterates a document of gift, an amendment, or revocation of a
8147 document of gift, or a refusal commits a third degree felony.

8148 Section 258. Section **26B-8-317**, which is renumbered from Section 26-28-118 is
8149 renumbered and amended to read:

8150 ~~[26-28-118]~~. **26B-8-317. Immunity.**

8151 (1) A person that acts in accordance with this ~~[chapter]~~ part or with the applicable
8152 anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act
8153 in a civil action, criminal prosecution, or administrative proceeding.

8154 (2) Neither the person making an anatomical gift nor the donor's estate is liable for any
8155 injury or damage that results from the making or use of the gift.

8156 (3) In determining whether an anatomical gift has been made, amended, or revoked
8157 under this [chapter] part, a person may rely upon representations of an individual listed in
8158 Subsection [~~26-28-109~~] 26B-8-308(1)(b), (c), (d), (e), (f), (g), (h), (i), or (j) relating to the
8159 individual's relationship to the donor or prospective donor unless the person knows that the
8160 representation is untrue.

8161 Section 259. Section **26B-8-318**, which is renumbered from Section 26-28-119 is
8162 renumbered and amended to read:

8163 [~~26-28-119~~]. **26B-8-318. Law governing validity -- Choice of law as to**
8164 **execution of document of gift -- Presumption of validity.**

8165 (1) A document of gift is valid if executed in accordance with:

8166 (a) this [chapter] part;

8167 (b) the laws of the state or country where it was executed; or

8168 (c) the laws of the state or country where the person making the anatomical gift was
8169 domiciled, has a place of residence, or was a national at the time the document of gift was
8170 executed.

8171 (2) If a document of gift is valid under this section, the law of this state governs the
8172 interpretation of the document of gift.

8173 (3) A person may presume that a document of gift or amendment of an anatomical gift
8174 is valid unless that person knows that it was not validly executed or was revoked.

8175 Section 260. Section **26B-8-319**, which is renumbered from Section 26-28-120 is
8176 renumbered and amended to read:

8177 [~~26-28-120~~]. **26B-8-319. Donor registry.**

8178 (1) The Department of Public Safety may establish or contract for the establishment of
8179 a donor registry.

8180 (2) The Driver License Division of the Department of Public Safety shall cooperate
8181 with a person that administers any donor registry that this state establishes, contracts for, or
8182 recognizes for the purpose of transferring to the donor registry all relevant information

8183 regarding a donor's making, amendment to, or revocation of an anatomical gift.

8184 (3) A donor registry shall:

8185 (a) allow a donor or other person authorized under Section [~~26-28-104~~] 26B-8-303 to
8186 include on the donor registry a statement or symbol that the donor has made, amended, or
8187 revoked an anatomical gift;

8188 (b) be accessible to a procurement organization to allow it to obtain relevant
8189 information on the donor registry to determine, at or near death of the donor or a prospective
8190 donor, whether the donor or prospective donor has made, amended, or revoked an anatomical
8191 gift; and

8192 (c) be accessible for purposes of Subsections (3)(a) and (b) seven days a week on a
8193 24-hour basis.

8194 (4) Personally identifiable information on a donor registry about a donor or prospective
8195 donor may not be used or disclosed without the express consent of the donor, prospective
8196 donor, or person that made the anatomical gift for any purpose other than to determine, at or
8197 near death of the donor or prospective donor, whether the donor or prospective donor has
8198 made, amended, or revoked an anatomical gift.

8199 (5) This section does not prohibit any person from creating or maintaining a donor
8200 registry that is not established by or under contract with the state. Any such registry shall
8201 comply with Subsections (3) and (4).

8202 Section 261. Section **26B-8-320**, which is renumbered from Section 26-28-121 is
8203 renumbered and amended to read:

8204 [~~26-28-121~~]. **26B-8-320. Effect of anatomical gift on advance health care**
8205 **directive.**

8206 (1) As used in this section:

8207 (a) "Advance health care directive" means a power of attorney for health care or a
8208 record signed or authorized by a prospective donor containing the prospective donor's direction
8209 concerning a health care decision for the prospective donor.

8210 (b) "Declaration" means a record signed by a prospective donor specifying the
8211 circumstances under which a life support system may be withheld or withdrawn from the
8212 prospective donor.

8213 (c) "Health care decision" means any decision regarding the health care of the
8214 prospective donor.

8215 (2) If a prospective donor has a declaration or advance health care directive and the
8216 terms of the declaration or directive and the express or implied terms of a potential anatomical
8217 gift are in conflict with regard to the administration of measures necessary to ensure the
8218 medical suitability of a part for transplantation or therapy, the prospective donor's attending
8219 physician and prospective donor shall confer to resolve the conflict. If the prospective donor is
8220 incapable of resolving the conflict, an agent acting under the prospective donor's declaration or
8221 directive, or if no declaration or directive exists or the agent is not reasonably available,
8222 another person authorized by a law other than this ~~[chapter]~~ part to make a health care decision
8223 on behalf of the prospective donor, shall act for the donor to resolve the conflict. The conflict
8224 shall be resolved as expeditiously as possible. Information relevant to the resolution of the
8225 conflict may be obtained from the appropriate procurement organization and any other person
8226 authorized to make an anatomical gift for the prospective donor under Section ~~[26-28-109]~~
8227 26B-8-308. Before resolution of the conflict, measures necessary to ensure the medical
8228 suitability of the part may not be withheld or withdrawn from the prospective donor if
8229 withholding or withdrawing the measures is not contraindicated by appropriate end of life care.

8230 Section 262. Section **26B-8-321**, which is renumbered from Section 26-28-122 is
8231 renumbered and amended to read:

8232 ~~[26-28-122]~~. **26B-8-321. Cooperation between medical examiner and**
8233 **procurement organization.**

8234 (1) A medical examiner shall cooperate with procurement organizations to maximize
8235 the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research,
8236 or education.

8237 (2) If a medical examiner receives notice from a procurement organization that an
8238 anatomical gift might be available or was made with respect to a decedent whose body is under
8239 the jurisdiction of the medical examiner and a postmortem examination is going to be
8240 performed, unless the medical examiner denies recovery in accordance with Section
8241 [~~26-28-123~~] 26B-8-322, the medical examiner or designee shall conduct a postmortem
8242 examination of the body or the part in a manner and within a period compatible with its
8243 preservation for the purposes of the gift.

8244 (3) A part may not be removed from the body of a decedent under the jurisdiction of a
8245 medical examiner for transplantation, therapy, research, or education unless the part is the
8246 subject of an anatomical gift. The body of a decedent under the jurisdiction of the medical
8247 examiner may not be delivered to a person for research or education unless the body is the
8248 subject of an anatomical gift. This Subsection (3) does not preclude a medical examiner from
8249 performing the medicolegal investigation upon the body or parts of a decedent under the
8250 jurisdiction of the medical examiner.

8251 Section 263. Section **26B-8-322**, which is renumbered from Section 26-28-123 is
8252 renumbered and amended to read:

8253 ~~[26-28-123]~~. **26B-8-322. Facilitation of anatomical gift from decedent**
8254 **whose body is under jurisdiction of medical examiner.**

8255 (1) Upon request of a procurement organization, a medical examiner shall release to
8256 the procurement organization the name, contact information, and available medical and social
8257 history of a decedent whose body is under the jurisdiction of the medical examiner. If the
8258 decedent's body or part is medically suitable for transplantation, therapy, research, or education,
8259 the medical examiner shall release postmortem examination results to the procurement
8260 organization. The procurement organization may make a subsequent disclosure of the
8261 postmortem examination results or other information received from the medical examiner only
8262 if relevant to transplantation or therapy.

8263 (2) The medical examiner may conduct a medicolegal examination by reviewing all

8264 medical records, laboratory test results, x-rays, other diagnostic results, and other information
8265 that any person possesses about a donor or prospective donor whose body is under the
8266 jurisdiction of the medical examiner which the medical examiner determines may be relevant
8267 to the investigation.

8268 (3) A person that has any information requested by a medical examiner pursuant to
8269 Subsection (2) shall provide that information as expeditiously as possible to allow the medical
8270 examiner to conduct the medicolegal investigation within a period compatible with the
8271 preservation of parts for the purpose of transplantation, therapy, research, or education.

8272 (4) If an anatomical gift has been or might be made of a part of a decedent whose body
8273 is under the jurisdiction of the medical examiner and a postmortem examination is not
8274 required, or the medical examiner determines that a postmortem examination is required but
8275 that the recovery of the part that is the subject of an anatomical gift will not interfere with the
8276 examination, the medical examiner and procurement organization shall cooperate in the timely
8277 removal of the part from the decedent for the purpose of transplantation, therapy, research, or
8278 education.

8279 (5) If an anatomical gift of a part from the decedent under the jurisdiction of the
8280 medical examiner has been or might be made, but the medical examiner initially believes that
8281 the recovery of the part could interfere with the postmortem investigation into the decedent's
8282 cause or manner of death, the medical examiner shall consult with the procurement
8283 organization or physician or technician designated by the procurement organization about the
8284 proposed recovery. After consultation, the medical examiner may allow the recovery.

8285 (6) Following the consultation under Subsection (5), in the absence of mutually agreed
8286 upon protocols to resolve conflict between the medical examiner and the procurement
8287 organization, if the medical examiner intends to deny recovery, the medical examiner or
8288 designee, at the request of the procurement organization, may attend the removal procedure for
8289 the part before making a final determination not to allow the procurement organization to
8290 recover the part. During the removal procedure, the medical examiner or designee may allow

8291 recovery by the procurement organization to proceed, or, if the medical examiner or designee
8292 reasonably believes that the part may be involved in determining the decedent's cause or
8293 manner of death, deny recovery by the procurement organization.

8294 (7) If the medical examiner or designee denies recovery under Subsection (6), the
8295 medical examiner or designee shall:

8296 (a) explain in a record the specific reasons for not allowing recovery of the part;

8297 (b) include the specific reasons in the records of the medical examiner; and

8298 (c) provide a record with the specific reasons to the procurement organization.

8299 (8) If the medical examiner or designee allows recovery of a part under Subsection (4),
8300 (5), or (6), the procurement organization, upon request, shall cause the physician or technician
8301 who removes the part to provide the medical examiner with a record describing the condition
8302 of the part, a biopsy, a photograph, and any other information and observations that would
8303 assist in the postmortem examination.

8304 (9) If a medical examiner or designee is required to be present at a removal procedure
8305 under Subsection (6), upon request the procurement organization requesting the recovery of the
8306 part shall reimburse the medical examiner or designee for the additional costs incurred in
8307 complying with Subsection (6).

8308 Section 264. Section **26B-8-323**, which is renumbered from Section 26-28-124 is
8309 renumbered and amended to read:

8310 ~~[26-28-124]~~. **26B-8-323. Uniformity of application and construction.**

8311 In applying and construing ~~[this]~~ the uniform act in this part, consideration shall be
8312 given to the need to promote uniformity of the law with respect to its subject matter among
8313 states that enact it.

8314 Section 265. Section **26B-8-324**, which is renumbered from Section 26-28-125 is
8315 renumbered and amended to read:

8316 ~~[26-28-125]~~. **26B-8-324. Relation to Electronic Signatures in Global and**
8317 **National Commerce Act.**

8318 This act modifies, limits, and supersedes the Electronic Signatures in Global and
8319 National Commerce Act, 15 U.S.C. [~~Section~~] Sec. 7001 et seq., but does not modify, limit or
8320 supersede Section 101(a) of that act, 15 U.S.C. [~~Section~~] Sec. 7001, or authorize electronic
8321 delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. [~~Section~~] Sec.
8322 7003(b).

8323 Section 266. Section **26B-8-401**, which is renumbered from Section 26-3-1 is
8324 renumbered and amended to read:

8325 **Part 4. Health Statistics**

8326 [~~26-3-1~~]. **26B-8-401. Definitions.**

8327 As used in this [~~chapter~~] part:

8328 (1) "Disclosure" or "disclose" means the communication of health data to any
8329 individual or organization outside the department.

8330 (2) "Health data" means any information, except vital records as defined in Section
8331 [~~26-2-2~~] 26B-8-101, relating to the health status of individuals, the availability of health
8332 resources and services, and the use and cost of these resources and services.

8333 (3) "Identifiable health data" means any item, collection, or grouping of health data
8334 which makes the individual supplying it or described in it identifiable.

8335 (4) "Individual" means a natural person.

8336 (5) "Organization" means any corporation, association, partnership, agency,
8337 department, unit, or other legally constituted institution or entity, or part of any of these.

8338 (6) "Research and statistical purposes" means the performance of activities relating to
8339 health data, including:

8340 (a) describing the group characteristics of individuals or organizations;

8341 (b) analyzing the interrelationships among the various characteristics of individuals or
8342 organizations;

8343 (c) the conduct of statistical procedures or studies to improve the quality of health data;

8344 (d) the design of sample surveys and the selection of samples of individuals or

8345 organizations;

8346 (e) the preparation and publication of reports describing these matters; and

8347 (f) other related functions.

8348 Section 267. Section **26B-8-402**, which is renumbered from Section 26-3-2 is

8349 renumbered and amended to read:

8350 ~~[26-3-2]~~. **26B-8-402. Powers of department to collect and maintain health**

8351 **data.**

8352 The department may on a voluntary basis, except when there is specific legal authority

8353 to compel reporting of health data:

8354 (1) collect and maintain health data on:

8355 (a) the extent, nature, and impact of illness and disability on the population of the state;

8356 (b) the determinants of health and health hazards;

8357 (c) health resources, including the extent of available manpower and resources;

8358 (d) utilization of health care;

8359 (e) health care costs and financing; or

8360 (f) other health or health-related matters;

8361 (2) undertake and support research, demonstrations, and evaluations respecting new or

8362 improved methods for obtaining current data on the matters referred to in Subsection (1) of this

8363 section; and

8364 (3) collect health data under other authorities and on behalf of other governmental or

8365 not-for-profit organizations.

8366 Section 268. Section **26B-8-403**, which is renumbered from Section 26-3-4 is

8367 renumbered and amended to read:

8368 ~~[26-3-4]~~. **26B-8-403. Quality and publication of statistics.**

8369 The department shall:

8370 (1) take such actions as may be necessary to assure that statistics developed under this

8371 ~~[chapter]~~ part are of high quality, timely, and comprehensive, as well as specific, standardized,

8372 and adequately analyzed and indexed; and

8373 (2) publish, make available, and disseminate such statistics on as wide a basis as
8374 practicable.

8375 Section 269. Section **26B-8-404**, which is renumbered from Section 26-3-5 is
8376 renumbered and amended to read:

8377 ~~[26-3-5]~~. **26B-8-404. Coordination of health data collection activities.**

8378 (1) The department shall coordinate health data activities within the state to eliminate
8379 unnecessary duplication of data collection and maximize the usefulness of data collected.

8380 (2) Except as specifically provided, this ~~[chapter]~~ part does not independently provide
8381 authority for the department to compel the reporting of information.

8382 Section 270. Section **26B-8-405**, which is renumbered from Section 26-3-6 is
8383 renumbered and amended to read:

8384 ~~[26-3-6]~~. **26B-8-405. Uniform standards -- Powers of department.**

8385 The department may:

8386 (1) participate and cooperate with state, local, and federal agencies and other
8387 organizations in the design and implementation of uniform standards for the management of
8388 health information at the federal, state, and local levels; and

8389 (2) undertake and support research, development, demonstrations, and evaluations that
8390 support uniform health information standards.

8391 Section 271. Section **26B-8-406**, which is renumbered from Section 26-3-7 is
8392 renumbered and amended to read:

8393 ~~[26-3-7]~~. **26B-8-406. Disclosure of health data -- Limitations.**

8394 The department may not ~~[disclose]~~ make a disclosure of any identifiable health data
8395 unless:

8396 (1) one of the following persons has consented to the disclosure:

8397 (a) the individual;

8398 (b) the next-of-kin if the individual is deceased;

8399 (c) the parent or legal guardian if the individual is a minor or mentally incompetent; or
8400 (d) a person holding a power of attorney covering such matters on behalf of the
8401 individual;

8402 (2) the disclosure is to a governmental entity in this or another state or the federal
8403 government, provided that:

8404 (a) the data will be used for a purpose for which they were collected by the department;
8405 and

8406 (b) the recipient enters into a written agreement satisfactory to the department agreeing
8407 to protect such data in accordance with the requirements of this [~~chapter~~] part and department
8408 rule and not permit further disclosure without prior approval of the department;

8409 (3) the disclosure is to an individual or organization, for a specified period, solely for
8410 bona fide research and statistical purposes, determined in accordance with department rules,
8411 and the department determines that the data are required for the research and statistical
8412 purposes proposed and the requesting individual or organization enters into a written
8413 agreement satisfactory to the department to protect the data in accordance with this [~~chapter~~]
8414 part and department rule and not permit further disclosure without prior approval of the
8415 department;

8416 (4) the disclosure is to a governmental entity for the purpose of conducting an audit,
8417 evaluation, or investigation of the department and such governmental entity agrees not to use
8418 those data for making any determination affecting the rights, benefits, or entitlements of any
8419 individual to whom the health data relates;

8420 (5) the disclosure is of specific medical or epidemiological information to authorized
8421 personnel within the department, local health departments, public health authorities, official
8422 health agencies in other states, the United States Public Health Service, the Centers for Disease
8423 Control and Prevention (CDC), or agencies responsible to enforce quarantine, when necessary
8424 to continue patient services or to undertake public health efforts to control communicable,
8425 infectious, acute, chronic, or any other disease or health hazard that the department considers to

8426 be dangerous or important or that may affect the public health;

8427 (6) (a) the disclosure is of specific medical or epidemiological information to a "health
8428 care provider" as defined in Section [78B-3-403](#), health care personnel, or public health
8429 personnel who has a legitimate need to have access to the information in order to assist the
8430 patient or to protect the health of others closely associated with the patient; and

8431 (b) this Subsection (6) does not create a duty to warn third parties;

8432 (7) the disclosure is necessary to obtain payment from an insurer or other third-party
8433 payor in order for the department to obtain payment or to coordinate benefits for a patient; or

8434 (8) the disclosure is to the subject of the identifiable health data.

8435 Section 272. Section **26B-8-407**, which is renumbered from Section 26-3-8 is
8436 renumbered and amended to read:

8437 ~~[26-3-8]~~. **26B-8-407. Disclosure of health data -- Discretion of department.**

8438 (1) Any disclosure provided for in Section ~~[26-3-7]~~ [26B-8-406](#) shall be made at the
8439 discretion of the department~~[, except that the]~~.

8440 (2) Notwithstanding Subsection (1), the disclosure provided for in Subsection ~~[26-3-7]~~
8441 [26B-8-406](#)(4) shall be made when the requirements of that paragraph are met.

8442 Section 273. Section **26B-8-408**, which is renumbered from Section 26-3-9 is
8443 renumbered and amended to read:

8444 ~~[26-3-9]~~. **26B-8-408. Health data not subject to subpoena or compulsory
8445 process -- Exception.**

8446 Identifiable health data obtained in the course of activities undertaken or supported
8447 under this ~~[chapter]~~ part may not be subject to discovery, subpoena, or similar compulsory
8448 process in any civil or criminal, judicial, administrative, or legislative proceeding, nor shall any
8449 individual or organization with lawful access to identifiable health data under the provisions of
8450 this ~~[chapter]~~ part be compelled to testify with regard to such health data, except that data
8451 pertaining to a party in litigation may be subject to subpoena or similar compulsory process in
8452 an action brought by or on behalf of such individual to enforce any liability arising under this

8453 [~~chapter~~] part.

8454 Section 274. Section **26B-8-409**, which is renumbered from Section 26-3-10 is
8455 renumbered and amended to read:

8456 ~~[26-3-10]~~. **26B-8-409. Department measures to protect security of health data.**

8457 The department shall protect the security of identifiable health data by use of the
8458 following measures and any other measures adopted by rule:

8459 (1) limit access to identifiable health data to authorized individuals who have received
8460 training in the handling of such data;

8461 (2) designate a person to be responsible for physical security;

8462 (3) develop and implement a system for monitoring security; and

8463 (4) review periodically all identifiable health data to determine whether identifying
8464 characteristics should be removed from the data.

8465 Section 275. Section **26B-8-410**, which is renumbered from Section 26-3-11 is
8466 renumbered and amended to read:

8467 ~~[26-3-11]~~. **26B-8-410. Relation to other provisions.**

8468 Because [~~Chapter 2, Utah Vital Statistics Act, Chapter 4, Utah Medical Examiner Act,~~
8469 ~~Chapter 6, Utah Communicable Disease Control Act, and Chapter 33a, Utah Health Data~~
8470 ~~Authority Act]~~ the following parts contain specific provisions regarding collection and
8471 disclosure of data, the provisions of this [~~chapter~~] part do not apply to data that is subject to
8472 [~~those chapters.~~] the following parts:

8473 (1) Part 1, Vital Statistics;

8474 (2) Part 2, Utah Medical Examiner; and

8475 (3) Sections [26B-7-201](#) through [26B-7-223](#).

8476 Section 276. Section **26B-8-411**, which is renumbered from Section 26-1-37 is
8477 renumbered and amended to read:

8478 ~~[26-1-37]~~. **26B-8-411. Duty to establish standards for the electronic exchange**
8479 **of clinical health information -- Immunity.**

8480 (1) [~~For purposes of~~] As used in this section:

8481 (a) "Affiliate" means an organization that directly or indirectly through one or more
8482 intermediaries controls, is controlled by, or is under common control with another
8483 organization.

8484 (b) "Clinical health information" shall be defined by the department by administrative
8485 rule adopted in accordance with Subsection (2).

8486 (c) "Electronic exchange":

8487 (i) includes:

8488 (A) the electronic transmission of clinical health data via Internet or extranet; and

8489 (B) physically moving clinical health information from one location to another using
8490 magnetic tape, disk, or compact disc media; and

8491 (ii) does not include exchange of information by telephone or fax.

8492 (d) "Health care provider" means a licensing classification that is either:

8493 (i) licensed under Title 58, Occupations and Professions, to provide health care; or

8494 (ii) licensed under [~~Chapter 21~~] Chapter 2, Part 2, Health Care Facility Licensing and
8495 Inspection [~~Act~~].

8496 (e) "Health care system" shall include:

8497 (i) affiliated health care providers;

8498 (ii) affiliated third party payers; and

8499 (iii) other arrangement between organizations or providers as described by the
8500 department by administrative rule.

8501 (f) "Qualified network" means an entity that:

8502 (i) is a non-profit organization;

8503 (ii) is accredited by the Electronic Healthcare Network Accreditation Commission, or
8504 another national accrediting organization recognized by the department; and

8505 (iii) performs the electronic exchange of clinical health information among multiple
8506 health care providers not under common control, multiple third party payers not under common

8507 control, the department, and local health departments.

8508 (g) "Third party payer" means:

8509 (i) all insurers offering health insurance who are subject to Section 31A-22-614.5; and

8510 (ii) the state Medicaid program.

8511 (2) (a) [~~In addition to the duties listed in Section 26-1-30, the~~] The department shall[;]
8512 make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

8513 (i) define:

8514 (A) "clinical health information" subject to this section; and

8515 (B) "health system arrangements between providers or organizations" as described in
8516 Subsection (1)(e)(iii); and

8517 (ii) adopt standards for the electronic exchange of clinical health information between
8518 health care providers and third party payers that are for treatment, payment, health care
8519 operations, or public health reporting, as provided for in 45 C.F.R. Parts 160, 162, and 164,
8520 Health Insurance Reform: Security Standards.

8521 (b) The department shall coordinate its rule making authority under the provisions of
8522 this section with the rule making authority of the Insurance Department under Section
8523 31A-22-614.5.

8524 (c) The department shall establish procedures for developing the rules adopted under
8525 this section, which ensure that the Insurance Department is given the opportunity to comment
8526 on proposed rules.

8527 (3) (a) Except as provided in Subsection (3)(e), a health care provider or third party
8528 payer in Utah is required to use the standards adopted by the department under the provisions
8529 of Subsection (2) if the health care provider or third party payer elects to engage in an
8530 electronic exchange of clinical health information with another health care provider or third
8531 party payer.

8532 (b) A health care provider or third party payer may [~~disclose~~] make a disclosure of
8533 information to the department or a local health department, by electronic exchange of clinical

8534 health information, as permitted by Subsection 45 C.F.R. Sec. 164.512(b).

8535 (c) When functioning in its capacity as a health care provider or payer, the department
8536 or a local health department may [~~disclose~~] make a disclosure of clinical health information by
8537 electronic exchange to another health care provider or third party payer.

8538 (d) An electronic exchange of clinical health information by a health care provider, a
8539 third party payer, the department, a local health department, or a qualified network is a
8540 disclosure for treatment, payment, or health care operations if it complies with Subsection
8541 (3)(a) or (c) and is for treatment, payment, or health care operations, as those terms are defined
8542 in 45 C.F.R. Parts 160, 162, and 164.

8543 (e) A health care provider or third party payer is not required to use the standards
8544 adopted by the department under the provisions of Subsection (2) if the health care provider or
8545 third party payer engage in the electronic exchange of clinical health information within a
8546 particular health care system.

8547 (4) Nothing in this section shall limit the number of networks eligible to engage in the
8548 electronic data interchange of clinical health information using the standards adopted by the
8549 department under Subsection (2)(a)(ii).

8550 (5) (a) The department, a local health department, a health care provider, a third party
8551 payer, or a qualified network is not subject to civil liability for a disclosure of clinical health
8552 information if the disclosure is in accordance with:

- 8553 (i) Subsection (3)(a); and
- 8554 (ii) Subsection (3)(b), (c), or (d).

8555 (b) The department, a local health department, a health care provider, a third party
8556 payer, or a qualified network that accesses or reviews clinical health information from or
8557 through the electronic exchange in accordance with the requirements in this section is not
8558 subject to civil liability for the access or review.

8559 (6) Within a qualified network, information generated or [~~disclosed~~] for which a
8560 disclosure is made in the electronic exchange of clinical health information is not subject to

8561 discovery, use, or receipt in evidence in any legal proceeding of any kind or character.

8562 Section 277. Section **26B-8-501**, which is renumbered from Section 26-33a-102 is
8563 renumbered and amended to read:

8564 **Part 5. Utah Health Data Authority**

8565 ~~[26-33a-102].~~ **26B-8-501. Definitions.**

8566 As used in this ~~[chapter]~~ part:

8567 (1) "Committee" means the Health Data Committee created ~~[by Section 26B-1-204]~~ in
8568 Section 26B-1-413.

8569 (2) "Control number" means a number assigned by the committee to an individual's
8570 health data as an identifier so that the health data can be disclosed or used in research and
8571 statistical analysis without readily identifying the individual.

8572 (3) "Data supplier" means a health care facility, health care provider, self-funded
8573 employer, third-party payor, health maintenance organization, or government department which
8574 could reasonably be expected to provide health data under this ~~[chapter]~~ part.

8575 (4) "Disclosure" or "disclose" means the communication of health care data to any
8576 individual or organization outside the committee, its staff, and contracting agencies.

8577 (5) (a) "Health care facility" means a facility that is licensed by the department under
8578 ~~[Title 26, Chapter 21]~~ Chapter 2, Part 2, Health Care Facility Licensing and Inspection [Act].

8579 (b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
8580 committee, with the concurrence of the department, may by rule add, delete, or modify the list
8581 of facilities that come within this definition for purposes of this ~~[chapter]~~ part.

8582 (6) "Health care provider" means ~~[any person, partnership, association, corporation, or~~
8583 ~~other facility or institution that renders or causes to be rendered health care or professional~~
8584 ~~services as a physician, physician assistant, registered nurse, licensed practical nurse,~~
8585 ~~nurse-midwife, dentist, dental hygienist, optometrist, clinical laboratory technologist,~~
8586 ~~pharmacist, physical therapist, podiatric physician, psychologist, chiropractic physician,~~
8587 ~~naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist,~~

8588 ~~speech pathologist, certified social worker, social service worker, social service aide, marriage~~
8589 ~~and family counselor, or practitioner of obstetrics, and others rendering similar care and~~
8590 ~~services relating to or arising out of the health needs of persons or groups of persons, and~~
8591 ~~officers, employees, or agents of any of the above acting in the course and scope of their~~
8592 ~~employment] the same as that term is defined in Section [78B-3-403](#).~~

8593 (7) "Health data" means information relating to the health status of individuals, health
8594 services delivered, the availability of health manpower and facilities, and the use and costs of
8595 resources and services to the consumer, except vital records as defined in Section ~~[26-2-2]~~
8596 [26B-8-101](#) shall be excluded.

8597 (8) "Health maintenance organization" ~~[has the meaning set forth]~~ means the same as
8598 that term is defined in Section [31A-8-101](#).

8599 (9) "Identifiable health data" means any item, collection, or grouping of health data that
8600 makes the individual supplying or described in the health data identifiable.

8601 (10) "Organization" means any corporation, association, partnership, agency,
8602 department, unit, or other legally constituted institution or entity, or part thereof.

8603 (11) "Research and statistical analysis" means activities using health data analysis
8604 including:

8605 (a) describing the group characteristics of individuals or organizations;

8606 (b) analyzing the noncompliance among the various characteristics of individuals or
8607 organizations;

8608 (c) conducting statistical procedures or studies to improve the quality of health data;

8609 (d) designing sample surveys and selecting samples of individuals or organizations;

8610 and

8611 (e) preparing and publishing reports describing these matters.

8612 (12) "Self-funded employer" means an employer who provides for the payment of
8613 health care services for employees directly from the employer's funds, thereby assuming the
8614 financial risks rather than passing them on to an outside insurer through premium payments.

8615 (13) "Plan" means the plan developed and adopted by the Health Data Committee
8616 under Section [~~26-33a-104~~] 26B-1-413.

8617 (14) "Third party payor" means:

8618 (a) an insurer offering a health benefit plan, as defined by Section 31A-1-301, to at
8619 least 2,500 enrollees in the state;

8620 (b) a nonprofit health service insurance corporation licensed under Title 31A, Chapter
8621 7, Nonprofit Health Service Insurance Corporations;

8622 (c) a program funded or administered by Utah for the provision of health care services,
8623 including the Medicaid and medical assistance programs described in [~~Chapter 18, Medical~~
8624 ~~Assistance Act~~] Chapter 3, Part 1, Health Care Assistance; and

8625 (d) a corporation, organization, association, entity, or person:

8626 (i) which administers or offers a health benefit plan to at least 2,500 enrollees in the
8627 state; and

8628 (ii) which is required by administrative rule adopted by the department in accordance
8629 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to supply health data to the
8630 committee.

8631 Section 278. Section **26B-8-502**, which is renumbered from Section 26-33a-105 is
8632 renumbered and amended to read:

8633 [~~26-33a-105~~]. **26B-8-502. Executive secretary -- Appointment -- Powers.**

8634 (1) An executive secretary shall be appointed by the executive director, with the
8635 approval of the committee, and shall serve under the administrative direction of the executive
8636 director.

8637 (2) The executive secretary shall:

8638 (a) employ full-time employees necessary to carry out this [~~chapter~~] part;

8639 (b) supervise the development of a draft health data plan for the committee's review,
8640 modification, and approval; and

8641 (c) supervise and conduct the staff functions of the committee in order to assist the

8642 committee in meeting its responsibilities under this ~~[chapter]~~ part.

8643 Section 279. Section **26B-8-503**, which is renumbered from Section 26-33a-106 is
8644 renumbered and amended to read:

8645 ~~[26-33a-106]~~. **26B-8-503. Limitations on use of health data.**

8646 The committee may not use the health data provided to it by third-party payors, health
8647 care providers, or health care facilities to make recommendations with regard to a single health
8648 care provider or health care facility, or a group of health care providers or health care facilities.

8649 Section 280. Section **26B-8-504**, which is renumbered from Section 26-33a-106.1 is
8650 renumbered and amended to read:

8651 ~~[26-33a-106.1]~~. **26B-8-504. Health care cost and reimbursement data.**

8652 (1) The committee shall, as funding is available:

8653 (a) establish a plan for collecting data from data suppliers to determine measurements
8654 of cost and reimbursements for risk-adjusted episodes of health care;

8655 (b) share data regarding insurance claims and an individual's and small employer
8656 group's health risk factor and characteristics of insurance arrangements that affect claims and
8657 usage with the Insurance Department, only to the extent necessary for:

8658 (i) risk adjusting; and

8659 (ii) the review and analysis of health insurers' premiums and rate filings; and

8660 (c) assist the Legislature and the public with awareness of, and the promotion of,
8661 transparency in the health care market by reporting on:

8662 (i) geographic variances in medical care and costs as demonstrated by data available to
8663 the committee; and

8664 (ii) rate and price increases by health care providers:

8665 (A) that exceed the Consumer Price Index - Medical as provided by the United States
8666 Bureau of Labor Statistics;

8667 (B) as calculated yearly from June to June; and

8668 (C) as demonstrated by data available to the committee;

8669 (d) provide on at least a monthly basis, enrollment data collected by the committee to a
8670 not-for-profit, broad-based coalition of state health care insurers and health care providers that
8671 are involved in the standardized electronic exchange of health data as described in Section
8672 [31A-22-614.5](#), to the extent necessary:

8673 (i) for the department or the Medicaid Office of the Inspector General to determine
8674 insurance enrollment of an individual for the purpose of determining Medicaid third party
8675 liability;

8676 (ii) for an insurer that is a data supplier, to determine insurance enrollment of an
8677 individual for the purpose of coordination of health care benefits; and

8678 (iii) for a health care provider, to determine insurance enrollment for a patient for the
8679 purpose of claims submission by the health care provider;

8680 (e) coordinate with the State Emergency Medical Services Committee to publish data
8681 regarding air ambulance charges under Section [~~26-8a-203~~] [26B-4-106](#);

8682 (f) share data collected under this [~~chapter~~] part with the state auditor for use in the
8683 health care price transparency tool described in Section [67-3-11](#); and

8684 (g) publish annually a report on primary care spending within Utah.

8685 (2) A data supplier is not liable for a breach of or unlawful disclosure of the data
8686 caused by an entity that obtains data in accordance with Subsection (1).

8687 (3) The plan adopted under Subsection (1) shall include:

8688 (a) the type of data that will be collected;

8689 (b) how the data will be evaluated;

8690 (c) how the data will be used;

8691 (d) the extent to which, and how the data will be protected; and

8692 (e) who will have access to the data.

8693 Section 281. Section **26B-8-505**, which is renumbered from Section 26-33a-106.5 is
8694 renumbered and amended to read:

8695 [~~26-33a-106.5~~]. **26B-8-505. Comparative analyses.**

8696 (1) The committee may publish compilations or reports that compare and identify
8697 health care providers or data suppliers from the data it collects under this [chapter] part or from
8698 any other source.

8699 (2) (a) Except as provided in Subsection (7)(c), the committee shall publish
8700 compilations or reports from the data it collects under this [chapter] part or from any other
8701 source which:

8702 (i) contain the information described in Subsection (2)(b); and

8703 (ii) compare and identify by name at least a majority of the health care facilities, health
8704 care plans, and institutions in the state.

8705 (b) Except as provided in Subsection (7)(c), the report required by this Subsection (2)
8706 shall:

8707 (i) be published at least annually;

8708 (ii) list, as determined by the committee, the median paid amount for at least the top 50
8709 medical procedures performed in the state by volume;

8710 (iii) describe the methodology approved by the committee to determine the amounts
8711 described in Subsection (2)(b)(ii); and

8712 (iv) contain comparisons based on at least the following factors:

8713 (A) nationally or other generally recognized quality standards;

8714 (B) charges; and

8715 (C) nationally recognized patient safety standards.

8716 (3) (a) The committee may contract with a private, independent analyst to evaluate the
8717 standard comparative reports of the committee that identify, compare, or rank the performance
8718 of data suppliers by name.

8719 (b) The evaluation described in this Subsection (3) shall include a validation of
8720 statistical methodologies, limitations, appropriateness of use, and comparisons using standard
8721 health services research practice.

8722 (c) The independent analyst described in Subsection (3)(a) shall be experienced in

8723 analyzing large databases from multiple data suppliers and in evaluating health care issues of
8724 cost, quality, and access.

8725 (d) The results of the analyst's evaluation shall be released to the public before the
8726 standard comparative analysis upon which it is based may be published by the committee.

8727 (4) ~~[It]~~ The committee, with the concurrence of the department, shall make rules in
8728 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, [the committee,
8729 ~~with the concurrence of the department, shall adopt by rule]~~ to adopt a timetable for the
8730 collection and analysis of data from multiple types of data suppliers.

8731 (5) The comparative analysis required under Subsection (2) shall be available free of
8732 charge and easily accessible to the public.

8733 (6) (a) The department shall include in the report required by Subsection (2)(b), or
8734 include in a separate report, comparative information on commonly recognized or generally
8735 agreed upon measures of cost and quality identified in accordance with Subsection (7), for:

8736 (i) routine and preventive care; and

8737 (ii) the treatment of diabetes, heart disease, and other illnesses or conditions as
8738 determined by the committee.

8739 (b) The comparative information required by Subsection (6)(a) shall be based on data
8740 collected under Subsection (2) and clinical data that may be available to the committee, and
8741 shall compare:

8742 (i) results for health care facilities or institutions;

8743 (ii) results for health care providers by geographic regions of the state;

8744 (iii) a clinic's aggregate results for a physician who practices at a clinic with five or
8745 more physicians; and

8746 (iv) a geographic region's aggregate results for a physician who practices at a clinic
8747 with less than five physicians, unless the physician requests physician-level data to be
8748 published on a clinic level.

8749 (c) The department:

8750 (i) may publish information required by this Subsection (6) directly or through one or
8751 more nonprofit, community-based health data organizations; and

8752 (ii) may use a private, independent analyst under Subsection (3)(a) in preparing the
8753 report required by this section.

8754 (d) A report published by the department under this Subsection (6):

8755 (i) is subject to the requirements of Section [~~26-33a-107~~] 26B-8-506; and

8756 (ii) shall, prior to being published by the department, be submitted to a neutral,
8757 non-biased entity with a broad base of support from health care payers and health care
8758 providers in accordance with Subsection (7) for the purpose of validating the report.

8759 (7) (a) The Health Data Committee shall, through the department, for purposes of
8760 Subsection (6)(a), use the quality measures that are developed and agreed upon by a neutral,
8761 non-biased entity with a broad base of support from health care payers and health care
8762 providers.

8763 (b) If the entity described in Subsection (7)(a) does not submit the quality measures,
8764 the department may select the appropriate number of quality measures for purposes of the
8765 report required by Subsection (6).

8766 (c) (i) For purposes of the reports published on or after July 1, 2014, the department
8767 may not compare individual facilities or clinics as described in Subsections (6)(b)(i) through
8768 (iv) if the department determines that the data available to the department can not be
8769 appropriately validated, does not represent nationally recognized measures, does not reflect the
8770 mix of cases seen at a clinic or facility, or is not sufficient for the purposes of comparing
8771 providers.

8772 (ii) The department shall report to the Legislature's Health and Human Services Interim
8773 Committee prior to making a determination not to publish a report under Subsection (7)(c)(i).

8774 Section 282. Section **26B-8-506**, which is renumbered from Section 26-33a-107 is
8775 renumbered and amended to read:

8776 [~~26-33a-107~~]. **26B-8-506. Limitations on release of reports.**

8777 The committee may not release a compilation or report that compares and identifies
8778 health care providers or data suppliers unless it:

8779 (1) allows the data supplier and the health care provider to verify the accuracy of the
8780 information submitted to the committee and submit to the committee any corrections of errors
8781 with supporting evidence and comments within a reasonable period of time to be established by
8782 rule, with the concurrence of the department, made in accordance with Title 63G, Chapter 3,
8783 Utah Administrative Rulemaking Act;

8784 (2) corrects data found to be in error; and

8785 (3) allows the data supplier a reasonable amount of time prior to publication to review
8786 the committee's interpretation of the data and prepare a response.

8787 Section 283. Section **26B-8-507**, which is renumbered from Section 26-33a-108 is
8788 renumbered and amended to read:

8789 ~~[26-33a-108].~~ **26B-8-507. Disclosure of identifiable health data prohibited.**

8790 (1) (a) All information, reports, statements, memoranda, or other data received by the
8791 committee are strictly confidential.

8792 (b) Any use, release, or publication of the information shall be done in such a way that
8793 no person is identifiable except as provided in Sections ~~[26-33a-107]~~ 26B-8-506 and
8794 ~~[26-33a-109]~~ 26B-8-508.

8795 (2) No member of the committee may be held civilly liable by reason of having
8796 released or published reports or compilations of data supplied to the committee, so long as the
8797 publication or release is in accordance with the requirements of Subsection (1).

8798 (3) No person, corporation, or entity may be held civilly liable for having provided data
8799 to the committee in accordance with this ~~[chapter]~~ part.

8800 Section 284. Section **26B-8-508**, which is renumbered from Section 26-33a-109 is
8801 renumbered and amended to read:

8802 ~~[26-33a-109].~~ **26B-8-508. Exceptions to prohibition on disclosure of**
8803 **identifiable health data.**

- 8804 (1) The committee may not disclose any identifiable health data unless:
- 8805 (a) the individual has authorized the disclosure;
- 8806 (b) the disclosure is to the department or a public health authority in accordance with
- 8807 Subsection (2); or
- 8808 (c) the disclosure complies with the provisions of:
- 8809 (i) Subsection (3);
- 8810 (ii) insurance enrollment and coordination of benefits under Subsection [~~26-33a-106.1~~]
- 8811 [26B-8-504](#)(1)(d); or
- 8812 (iii) risk adjusting under Subsection [~~26-33a-106.1~~] [26B-8-504](#)(1)(b).
- 8813 (2) The committee may disclose identifiable health data to the department or a public
- 8814 health authority under Subsection (1)(b) if:
- 8815 (a) the department or the public health authority has clear statutory authority to possess
- 8816 the identifiable health data; and
- 8817 (b) the disclosure is solely for use:
- 8818 (i) in the Utah Statewide Immunization Information System operated by the
- 8819 department;
- 8820 (ii) in the Utah Cancer Registry operated by the University of Utah, in collaboration
- 8821 with the department; or
- 8822 (iii) by the medical examiner, as defined in Section [~~26-4-2~~] [26B-8-201](#), or the medical
- 8823 examiner's designee.
- 8824 (3) The committee shall consider the following when responding to a request for
- 8825 disclosure of information that may include identifiable health data:
- 8826 (a) whether the request comes from a person after that person has received approval to
- 8827 do the specific research or statistical work from an institutional review board; and
- 8828 (b) whether the requesting entity complies with the provisions of Subsection (4).
- 8829 (4) A request for disclosure of information that may include identifiable health data
- 8830 shall:

8831 (a) be for a specified period; or
8832 (b) be solely for bona fide research or statistical purposes as determined in accordance
8833 with administrative rules adopted by the department in accordance with Title 63G, Chapter 3,
8834 Utah Administrative Rulemaking Act, which shall require:
8835 (i) the requesting entity to demonstrate to the department that the data is required for
8836 the research or statistical purposes proposed by the requesting entity; and
8837 (ii) the requesting entity to enter into a written agreement satisfactory to the department
8838 to protect the data in accordance with this ~~chapter~~ part or other applicable law.
8839 (5) A person accessing identifiable health data pursuant to Subsection (4) may not
8840 further disclose the identifiable health data:
8841 (a) without prior approval of the department; and
8842 (b) unless the identifiable health data is disclosed or identified by control number only.
8843 (6) Identifiable health data that has been designated by a data supplier as being subject
8844 to regulation under 42 C.F.R. Part 2, Confidentiality of Substance Use Disorder Patient
8845 Records, may only be used or disclosed in accordance with applicable federal regulations.
8846 Section 285. Section **26B-8-509**, which is renumbered from Section 26-33a-110 is
8847 renumbered and amended to read:
8848 ~~[26-33a-110].~~ **26B-8-509. Penalties.**
8849 (1) Any use, release, or publication of health care data contrary to the provisions of
8850 Sections ~~[26-33a-108 and 26-33a-109]~~ 26B-8-507 and 26B-8-508 is a class A misdemeanor.
8851 (2) Subsection (1) does not relieve the person or organization responsible for that use,
8852 release, or publication from civil liability.
8853 Section 286. Section **26B-8-510**, which is renumbered from Section 26-33a-111 is
8854 renumbered and amended to read:
8855 ~~[26-33a-111].~~ **26B-8-510. Health data not subject to subpoena or**
8856 **compulsory process -- Exception.**
8857 Identifiable health data obtained in the course of activities undertaken or supported

8858 under this [~~chapter~~] part are not subject to subpoena or similar compulsory process in any civil
8859 or criminal, judicial, administrative, or legislative proceeding, nor shall any individual or
8860 organization with lawful access to identifiable health data under the provisions of this [~~chapter~~]
8861 part be compelled to testify with regard to such health data, except that data pertaining to a
8862 party in litigation may be subject to subpoena or similar compulsory process in an action
8863 brought by or on behalf of such individual to enforce any liability arising under this [~~chapter~~]
8864 part.

8865 Section 287. Section **26B-8-511**, which is renumbered from Section 26-33a-115 is
8866 renumbered and amended to read:

8867 [~~26-33a-115~~]. **26B-8-511. Consumer-focused health care delivery and**
8868 **payment reform demonstration project.**

8869 (1) The Legislature finds that:

8870 (a) current health care delivery and payment systems do not provide system wide
8871 incentives for the competitive delivery and pricing of health care services to consumers;

8872 (b) there is a compelling state interest to encourage consumers to seek high quality, low
8873 cost care and educate themselves about health care options;

8874 (c) some health care providers and health care payers have developed
8875 consumer-focused ideas for health care delivery and payment system reform, but lack the
8876 critical number of patient lives and payer involvement to accomplish system-wide
8877 consumer-focused reform; and

8878 (d) there is a compelling state interest to encourage as many health care providers and
8879 health care payers to join together and coordinate efforts at consumer-focused health care
8880 delivery and payment reform that would provide to consumers enrolled in a high-deductible
8881 health plan:

8882 (i) greater choice in health care options;

8883 (ii) improved services through competition; and

8884 (iii) more affordable options for care.

8885 (2) (a) The department shall meet with health care providers and health care payers for
8886 the purpose of coordinating a demonstration project for consumer-based health care delivery
8887 and payment reform.

8888 (b) Participation in the coordination efforts is voluntary, but encouraged.

8889 (3) The department, in order to facilitate the coordination of a demonstration project
8890 for consumer-based health care delivery and payment reform, shall convene and consult with
8891 pertinent entities including:

8892 (a) the Utah Insurance Department;

8893 (b) the Office of Consumer [Health] Services;

8894 (c) the Utah Medical Association;

8895 (d) the Utah Hospital Association; and

8896 (e) neutral, non-biased third parties with an established record for broad based,
8897 multi-provider and multi-payer quality assurance efforts and data collection.

8898 (4) The department shall supervise the efforts by entities under Subsection (3)
8899 regarding:

8900 (a) applying for and obtaining grant funding and other financial assistance that may be
8901 available for demonstrating consumer-based improvements to health care delivery and
8902 payment;

8903 (b) obtaining and analyzing information and data related to current health system
8904 utilization and costs to consumers; and

8905 (c) consulting with those health care providers and health care payers who elect to
8906 participate in the consumer-based health delivery and payment demonstration project.

8907 ~~[(5) The executive director shall report to the Health System Reform Task Force by
8908 January 1, 2015, regarding the progress toward coordination of consumer-focused health care
8909 system payment and delivery reform.]~~

8910 Section 288. Section **26B-8-512**, which is renumbered from Section 26-33a-116 is
8911 renumbered and amended to read:

8912 ~~[26-33a-116]~~. **26B-8-512. Health care billing data.**

8913 (1) Subject to Subsection (2), the department shall make aggregate data produced
 8914 under this ~~[chapter]~~ part available to the public through a standardized application program
 8915 interface format.

8916 (2) (a) The department shall ensure that data made available to the public under
 8917 Subsection (1):

8918 (i) does not contain identifiable health data of a patient; and

8919 (ii) meets state and federal data privacy requirements, including the requirements of
 8920 Section ~~[26-33a-107]~~ 26B-8-506.

8921 (b) The department may not release any data under Subsection (1) that may be
 8922 identifiable health data of a patient.

8923 Section 289. Section **26B-8-513**, which is renumbered from Section 26-33a-117 is
 8924 renumbered and amended to read:

8925 ~~[26-33a-117]~~. **26B-8-513. Identifying potential overuse of**
 8926 **non-evidence-based health care.**

8927 (1) The department shall, in accordance with Title 63G, Chapter 6a, Utah Procurement
 8928 Code, contract with an entity to provide a nationally-recognized health waste calculator that:

8929 (a) uses principles such as the principles of the Choosing Wisely initiative of the
 8930 American Board of Internal Medicine Foundation; and

8931 (b) is approved by the committee.

8932 (2) The department shall use the calculator described in Subsection (1) to:

8933 (a) analyze the data in the state's All Payer Claims Database; and

8934 (b) flag data entries that the calculator identifies as potential overuse of non-
 8935 evidence-based health care.

8936 (3) The department, or a third party organization that the department contracts with in
 8937 accordance with Title 63G, Chapter 6a, Utah Procurement Code, shall:

8938 (a) analyze the data described in Subsection (2)(b);

8939 (b) review current scientific literature about medical services that are best practice;
8940 (c) review current scientific literature about eliminating duplication in health care;
8941 (d) solicit input from Utah health care providers, health systems, insurers, and other
8942 stakeholders regarding duplicative health care quality initiatives and instances of
8943 non-alignment in metrics used to measure health care quality that are required by different
8944 health systems;

8945 (e) solicit input from Utah health care providers, health systems, insurers, and other
8946 stakeholders on methods to avoid overuse of non-evidence-based health care; and

8947 (f) present the results of the analysis, research, and input described in Subsections
8948 (3)(a) through (e) to the committee.

8949 (4) The committee shall:

8950 (a) make recommendations for action and opportunities for improvement based on the
8951 results described in Subsection (3)(f);

8952 (b) make recommendations on methods to bring into alignment the various health care
8953 quality metrics different entities in the state use; and

8954 (c) identify priority issues and recommendations to include in an annual report.

8955 (5) The department, or the third party organization described in Subsection (3) shall:

8956 (a) compile the report described in Subsection (4)(c); and

8957 (b) submit the report to the committee for approval.

8958 (6) Beginning in 2021, on or before November 1 each year, the department shall
8959 submit the report approved in Subsection (5)(b) to the Health and Human Services Interim
8960 Committee.

8961 Section 290. Section **26B-8-514**, which is renumbered from Section 26-70-102 is
8962 renumbered and amended to read:

8963 ~~[26-70-102]~~. **26B-8-514. Standard health record access form.**

8964 (1) As used in this section:

8965 (a) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996,

8966 Pub. L. No. 104-191, 110 Stat. 1936, as amended.

8967 (b) "Patient" means the individual whose information is being requested.

8968 (c) "Personal representative" means an individual described in 45 C.F.R. Sec.

8969 164.502(g).

8970 ~~[(1)]~~ (2) Before December 31, 2022, the department shall create a standard form that:

8971 (a) is compliant with HIPAA and 42 C.F.R. Part 2; and

8972 (b) a patient or a patient's personal representative may use to request that a copy of the

8973 patient's health records be sent to any of the following:

8974 (i) the patient;

8975 (ii) the patient's personal representative;

8976 (iii) the patient's attorney; or

8977 (iv) a third party authorized by the patient.

8978 ~~[(2)]~~ (3) The form described in Subsection (2) shall include fields for:

8979 (a) the patient's name;

8980 (b) the patient's date of birth;

8981 (c) the patient's phone number;

8982 (d) the patient's address;

8983 (e) (i) the patient's signature and date of signature, which may not require notarization;

8984 or

8985 (ii) the signature of the patient's personal representative and date of signature, which

8986 may not require notarization;

8987 (f) the name, address, and phone number of the person to which the information will be

8988 disclosed;

8989 (g) the records requested, including whether the patient is requesting paper or

8990 electronic records;

8991 (h) the duration of time the authorization is valid; and

8992 (i) the dates of service requested.

8993 ~~[(3)]~~ (4) The form described in Subsection (2) shall include the following options for
8994 the field described in Subsection ~~[(2)]~~ (3)(g):

- 8995 (a) history and physical examination records;
- 8996 (b) treatment plans;
- 8997 (c) emergency room records;
- 8998 (d) radiology and lab reports;
- 8999 (e) operative reports;
- 9000 (f) pathology reports;
- 9001 (g) consultations;
- 9002 (h) discharge summary;
- 9003 (i) outpatient clinic records and progress notes;
- 9004 (j) behavioral health evaluation;
- 9005 (k) behavioral health discharge summary;
- 9006 (l) mental health therapy records;
- 9007 (m) financial information including an itemized billing statement;
- 9008 (n) health insurance claim form;
- 9009 (o) billing form; and
- 9010 (p) other.

9011 Section 291. **Coordinating S.B. 39 with S.B. 93 -- Substantive and technical**
9012 **amendments.**

9013 If this S.B. 39 and S.B. 93, Birth Certificate Modifications, both pass and become law,
9014 it is the intent of the Legislature that on May 3, 2023, the Office of Legislative Research and
9015 General Counsel prepare the Utah Code database for publication by:

9016 (1) in Section 26B-8-101 in this bill:

9017 (a) enacting the amendment to Subsection 26-2-2(2) in S.B. 93 as a new Subsection
9018 26B-8-101(2) in this S.B. 39 that reads:

9019 "(2) "Biological sex at birth" means an individual's sex, as being male or female,

9020 according to distinct reproductive roles as manifested by sex and reproductive organ anatomy,
9021 chromosomal makeup, and endogenous hormone profiles.";

9022 (b) enacting the amendment to Subsection 26-2-2(14) in S.B. 93 as a new Subsection
9023 26B-8-101(14) in this S.B. 39 that reads:

9024 "(14) "Intersex individual" means an individual who:

9025 (a) is born with external biological sex characteristics that are irresolvably ambiguous;

9026 (b) is born with 46, XX chromosomes with virilization;

9027 (c) is born with 46, XY chromosomes with undervirilization;

9028 (d) has both ovarian and testicular tissue; or

9029 (e) has been diagnosed by a physician, based on genetic or biochemical testing, with
9030 abnormal:

9031 (i) sex chromosome structure;

9032 (ii) sex steroid hormone production; or

9033 (iii) sex steroid hormone action for a male or female."; and

9034 (c) renumbering the subsections in Section 26B-8-101 accordingly; and

9035 (2) renumbering Section 26-2-11 in S.B. 93 to Section 26B-8-111.

9036 Section 292. **Revisor instructions.**

9037 The Legislature intends that the Office of Legislative Research and General Counsel, in
9038 preparing the Utah Code database for publication:

9039 (1) not enroll this bill if any of the following bills do not pass:

9040 (a) S.B. 38, Health and Human Services Recodification - Administration, Licensing,
9041 and Recovery Services;

9042 (b) S.B. 40, Health and Human Services Recodification - Health Care Delivery and
9043 Repeals; or

9044 (c) S.B. 41, Health and Human Services Recodification - Prevention, Supports,
9045 Substance Use and Mental Health; and

9046 (2) in any new language added to the Utah Code by legislation passed during the 2023

S.B. 39

Enrolled Copy

9047 General Session, replace any references to Title 26 or 62A with the renumbered reference as it
9048 is renumbered in this bill.