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H.B. 501

MEDICAID MODIFICATIONS

2024 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: _____

LONG TITLE

General Description:

This bill updates Medicaid provisions.

Highlighted Provisions:

This bill:

- amends or repeals obsolete Medicaid provisions and makes conforming changes;
- requires the department to apply for a Medicaid waiver or amend an existing waiver application related to qualified inmates in prison or jail; and
- modifies provisions related to how a health insurance entity interacts with the Medicaid program.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26B-1-316, as last amended by Laws of Utah 2023, Chapter 495 and renumbered and amended by Laws of Utah 2023, Chapter 305

26B-1-332, as renumbered and amended by Laws of Utah 2023, Chapter 305

26B-3-108, as last amended by Laws of Utah 2023, Chapter 466 and renumbered and amended by Laws of Utah 2023, Chapter 306

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26B-3-110, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-111, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-112, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-126, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-136, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-201, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-203, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-205, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-217, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-224, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-226, as enacted by Laws of Utah 2023, Chapter 336
26B-3-401, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-403, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-503, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-504, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-511, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-512, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-605, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-607, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-610, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-705, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-707, as last amended by Laws of Utah 2023, Chapter 495 and renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-803, as renumbered and amended by Laws of Utah 2023, Chapter 306
26B-3-1004, as renumbered and amended by Laws of Utah 2023, Chapter 306
63C-18-202, as last amended by Laws of Utah 2023, Chapters 270, 329
REPEALS:
26B-3-138, as renumbered and amended by Laws of Utah 2023, Chapter 306

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

Section 1. Section **26B-1-316** is amended to read:

26B-1-316. Hospital Provider Assessment Expendable Revenue Fund.

(1) There is created an expendable special revenue fund known as the "Hospital Provider Assessment Expendable Revenue Fund."

(2) The fund shall consist of:

(a) the assessments collected by the department under Chapter 3, Part 7, Hospital Provider Assessment;

(b) any interest and penalties levied with the administration of Chapter 3, Part 7, Hospital Provider Assessment; and

(c) any other funds received as donations for the fund and appropriations from other sources.

(3) Money in the fund shall be used:

(a) to support capitated rates consistent with Subsection 26B-3-705(1)(d) for accountable care organizations as defined in Section 26B-3-701;

(b) to implement the quality strategies described in Subsection 26B-3-707(2), except that the amount under this Subsection (3)(b) may not exceed $211,300 in each fiscal year; and

(c) to reimburse money collected by the division from a hospital, as defined in Section 26B-3-701, through a mistake made under Chapter 3, Part 7, Hospital Provider Assessment.

[~~(4) (a) Subject to Subsection (4)(b), for the fiscal year beginning July 1, 2019, and ending July 1, 2020, any fund balance in excess of the amount necessary to pay for the costs described in Subsection (3) shall be deposited into the General Fund.~~]

[~~(b) Subsection (4)(a) applies only to funds that were appropriated by the Legislature from the General Fund to the fund and the interest and penalties deposited into the fund under Subsection (2)(b).~~]

Section 2. Section **26B-1-332** is amended to read:

26B-1-332. Nursing Care Facilities Provider Assessment Fund -- Creation -- Administration -- Uses.

(1) There is created an expendable special revenue fund known as the "Nursing Care Facilities Provider Assessment Fund" consisting of:

(a) [~~the~~] assessments collected by the department under Chapter 3, Part 4, Nursing Care Facility Assessment;

(b) fines paid by nursing care facilities for excessive Medicare inpatient revenue under

Section 26B-2-222;

(c) money appropriated or otherwise made available by the Legislature;

(d) any interest earned on the fund; and

(e) penalties levied with the administration of Chapter 3, Part 4, Nursing Care Facility Assessment.

(2) Money in the fund shall only be used by the Medicaid program:

(a) to the extent authorized by federal law, to obtain federal financial participation in the Medicaid program;

(b) to provide the increased level of hospice reimbursement resulting from the nursing care facilities assessment imposed under Section 26B-3-403;

(c) for the Medicaid program to make quality incentive payments to nursing care facilities, subject to CMS approval of a Medicaid state plan amendment [~~to do so by the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services~~];

(d) to increase the rates paid before July 1, 2004, to nursing care facilities for providing services pursuant to the Medicaid program; and

(e) for administrative expenses, if the administrative expenses for the fiscal year do not exceed 3% of the money deposited into the fund during the fiscal year.

(3) The department may not spend the money in the fund to replace existing state expenditures paid to nursing care facilities for providing services under the Medicaid program, except for increased costs due to hospice reimbursement under Subsection (2)(b).

Section 3. Section **26B-3-108** is amended to read:

26B-3-108. Administration of Medicaid program by department -- Reporting to the Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility standards -- Optional dental services costs and delivery -- Internal audits -- Health opportunity accounts.

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

(2) (a) The department shall implement the Medicaid program through administrative rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking

Act, the requirements of Title XIX, and applicable federal regulations.

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

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

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

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

(iv) a requirement that:

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

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

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

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

(i) implements a change in the Medicaid State Plan;

(ii) initiates a new Medicaid waiver;

(iii) initiates an amendment to an existing Medicaid waiver;

(iv) applies for an extension of an application for a waiver or an existing Medicaid waiver;

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

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

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

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

(ii) include:

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

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

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

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

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

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

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

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

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

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

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

(5) The department may, in its discretion, contract with other qualified agencies for services in connection with the administration of the Medicaid program, including:

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

(b) recovery of overpayments; and

(c) consistent with Section 26B-3-1113, and to the extent permitted by law and quality control services, enforcement of fraud and abuse laws.

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

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

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

(7) (a) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited [~~in~~] into the General Fund as dedicated credits to be used by the division in accordance with the requirements of Section 1919 of Title XIX of the federal Social Security Act.

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

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

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

(i) the federal government shall:

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

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

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

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

(9) (a) As used in this Subsection (9):

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

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

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

(i) the allowable income standard for eligibility for services or benefits; and

(ii) the allowable income standard for eligibility as a result of spend down.

(10) The department shall conduct internal audits of the Medicaid program.

[~~(11) (a) The department may apply for and, if approved, implement a demonstration program for health opportunity accounts, as provided for in 42 U.S.C. Sec. 1396u-8.~~]

[~~(b) A health opportunity account established under Subsection (11)(a) shall be an alternative to the existing benefits received by an individual eligible to receive Medicaid under this chapter.~~]

[~~(c) Subsection (11)(a) is not intended to expand the coverage of the Medicaid program.~~]

[~~(12)~~] (11) (a) (i) The department shall apply for, and if approved, implement an amendment to the state plan under this Subsection [~~(12)~~] (11) for benefits for:

(A) medically needy pregnant women;

(B) medically needy children; and

(C) medically needy parents and caretaker relatives.

(ii) The department may implement the eligibility standards of Subsection [~~(12)(b)~~] (11)(b) for eligibility determinations made on or after the date of the approval of the amendment to the state plan.

(b) In determining whether an applicant is eligible for benefits described in Subsection [~~(12)(a)(i)~~] (11)(a)(i), the department shall:

(i) disregard resources held in an account in [~~the~~] a savings plan created under Title 53B, Chapter 8a, Utah Educational Savings Plan, if the beneficiary of the account is:

(A) under the age of 26; and

(B) living with the account owner, as that term is defined in Section 53B-8a-102, or temporarily absent from the residence of the account owner; and

(ii) include [~~the~~] withdrawals from an account in the Utah Educational Savings Plan as resources for a benefit determination, if the [~~withdrawal was~~] withdrawals were not used for qualified higher education costs as that term is defined in Section 53B-8a-102.5.

[~~(13)~~] (12) (a) The department may not deny or terminate eligibility for Medicaid solely because an individual is:

(i) incarcerated; and

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

(b) Subsection [~~(13)(a)~~] (12)(a) does not require the Medicaid program to provide

coverage for any services for an individual while the individual is incarcerated.

[~~(14)~~] (13) The department is a party to, and may intervene at any time in, any judicial or administrative action:

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

(b) that involves medical assistance under this chapter.

[~~(15)~~] (14) (a) The department may not deny or terminate eligibility for Medicaid solely because a birth mother, as that term is defined in Section 78B-6-103, considers an adoptive placement for the child or proceeds with an adoptive placement of the child.

(b) A health care provider, as that term is defined in Section 26B-3-126, may not decline payment by Medicaid for covered health and medical services provided to a birth mother, as that term is defined in Section 78B-6-103, who is enrolled in Utah's Medicaid program and who considers an adoptive placement for the child or proceeds with an adoptive placement of the child.

Section 4. Section **26B-3-110** is amended to read:

26B-3-110. Copayments by recipients -- Employer sponsored plans.

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

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

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

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

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

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

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

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

or

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

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

Section 5. Section **26B-3-111** is amended to read:

26B-3-111. Income and resources from institutionalized spouses.

(1) As used in this section:

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

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

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

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

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

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

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

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

(g) "Nursing care facility" means the same as that term is defined in Section 26B-2-201.

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

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

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

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

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

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

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

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

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

(7) (a) The division may not find an institutionalized spouse to be ineligible for

medical assistance by reason of resources determined under Subsection (5) to be available for the cost of care when:

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

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

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

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

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

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

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

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

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

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

(10) The division shall establish a minimum monthly maintenance needs allowance for each community spouse that includes:

(a) an amount established by the division by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the

United States Department of Health and Human Services; and

(b) an excess shelter allowance.

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

(b) A hearing under this subsection regarding the community spouse resource allowance shall be held by the division within 90 days from the date of the request for the hearing.

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

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

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

(i) the community spouse monthly income allowance;

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

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

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

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

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

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

(c) Part 10, Medical Benefits Recovery, does not apply if a court has entered an order against an institutionalized spouse for the support of the community spouse.

Section 6. Section **26B-3-112** is amended to read:

26B-3-112. Maximizing use of premium assistance programs -- Utah's Premium Partnership for Health Insurance.

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

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

(i) include, as necessary, seeking federal approval under all Medicaid and Children's Health Insurance Program premium assistance provisions of federal law, including provisions of PPACA;

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

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

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

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

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

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

(4) [~~Beginning with the fiscal year 2021-22, and in~~] In each [~~subsequent~~] fiscal year,

the department may increase premium subsidies for single adults and parents who have an offer of employer-sponsored insurance to keep pace with the increase in insurance premium costs, subject to appropriation of additional funding.

Section 7. Section **26B-3-126** is amended to read:

26B-3-126. Patient notice of health care provider privacy practices.

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

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

(A) receives payment for medical services from the Medicaid program established in this chapter, or the Children's Health Insurance Program established in Section 26B-3-902; and

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

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

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

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

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

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

Section 8. Section **26B-3-136** is amended to read:

26B-3-136. Children's Health Care Coverage Program.

(1) As used in this section:

(a) "CHIP" means the Children's Health Insurance Program created in Section

26B-3-902.

(b) "Program" means the Children's Health Care Coverage Program created in Subsection (2).

(2) (a) There is created the Children's Health Care Coverage Program within the department.

(b) The purpose of the program is to:

(i) promote health insurance coverage for children in accordance with Section 26B-3-124;

(ii) conduct research regarding families who are eligible for Medicaid and CHIP to determine awareness and understanding of available coverage;

(iii) analyze trends in disenrollment and identify reasons that families may not be renewing enrollment, including any barriers in the process of renewing enrollment;

(iv) administer surveys to recently enrolled CHIP members, as defined in Section 26B-3-901, and children's Medicaid enrollees to identify:

(A) how the enrollees learned about coverage; and

(B) any barriers during the application process;

(v) develop promotional material regarding CHIP and children's Medicaid eligibility, including outreach through social media, video production, and other media platforms;

(vi) identify ways that the eligibility website for enrollment in CHIP and children's Medicaid can be redesigned to increase accessibility and enhance the user experience;

(vii) identify outreach opportunities, including partnerships with community organizations including:

(A) schools;

(B) small businesses;

(C) unemployment centers;

(D) parent-teacher associations; and

(E) youth athlete clubs and associations; and

(viii) develop messaging to increase awareness of coverage options that are available through the department.

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

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

Section 9. Section **26B-3-201** is amended to read:

26B-3-201. Independent foster care adolescents.

(1) As used in this section, an "independent foster care adolescent" includes any individual who reached 18 years old while in the custody of the department if the department was the primary case manager, or a federally recognized Indian tribe.

(2) An independent foster care adolescent is eligible, when funds are available, for Medicaid coverage until the individual reaches 21 years old.

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

Section 10. Section **26B-3-203** is amended to read:

26B-3-203. Base budget appropriations for Medicaid accountable care organizations and behavioral health plans -- Forecast of behavioral health services cost.

(1) As used in this section:

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

(i) physical health services; or

(ii) integrated physical and behavioral health services.

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

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

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

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

(f) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal year ongoing General Fund revenue estimate identified by the Executive Appropriations

Committee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal Analyst in preparing budget recommendations.

(g) "Member" means an enrollee.

[~~(g)~~] (h) "PMPM" means per-member-per-month funding.

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

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

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

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

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

(7) The Office of the Legislative Fiscal Analyst shall include an estimate of the cost of behavioral health services in any state Medicaid funding or savings forecast that is completed

in coordination with the department and the Governor's Office of Planning and Budget.

Section 11. Section **26B-3-205** is amended to read:

26B-3-205. Long-term care insurance partnership.

(1) As used in this section:

(a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec. 7702B(b).

(b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec. 1396p(b)(1)(C)(iii).

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

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

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

Section 12. Section **26B-3-217** is amended to read:

26B-3-217. Medicaid waiver for coverage of qualified inmates leaving prison or jail.

(1) As used in this section:

(a) "Correctional facility" means:

(i) a county jail;

[~~(ii) the Department of Corrections, created in Section 64-13-2; or~~]

[~~(iii)~~] (ii) a prison, penitentiary, or other institution operated by or under contract with the Department of Corrections for the confinement of an offender, as defined in Section 64-13-1[~~-~~]; or

(iii) a juvenile correctional facility.

(b) "Limited Medicaid benefit" means:

(i) reentry case management services;

(ii) physical and behavioral health clinical services;

(iii) medications and medication administration;

(iv) medication-assisted treatment, including all United States Food and Drug

Administration approved medications, including coverage for counseling; and

(v) other services as determined by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(c) "Qualified inmate" means an individual who:

(i) is incarcerated in a correctional facility; and

(ii) is ineligible for Medicaid as a result of incarceration but would otherwise qualify under the state plan.

[~~(ii) has:~~]

[~~(A) a chronic physical or behavioral health condition;~~]

[~~(B) a mental illness, as defined in Section 26B-5-301; or~~]

[~~(C) an opioid use disorder.~~]

(2) [~~Before July 1, 2020~~] Subject to appropriation, before July 1, 2024, the division shall apply for a Medicaid waiver [~~or a state plan amendment~~], or amend an existing Medicaid waiver application, with CMS to offer a program to provide a limited Medicaid [~~coverage~~] benefit to a qualified inmate for up to [~~30~~] 90 days immediately before the day on which the qualified inmate is released from a correctional facility.

(3) (a) Monetary savings that result from the use of federal funds provided under this section shall be used in accordance with a reinvestment plan as mandated by CMS.

(b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules for a participating county to establish a reinvestment plan described in Subsection (3)(a).

[~~(3)~~] (4) If the waiver [~~or state plan amendment~~] or amended waiver described in Subsection (2) is approved, the department shall report to the Health and Human Services Interim Committee each year before November 30 while the waiver [~~or state plan amendment~~] is in effect regarding:

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

(b) the cost of the program; and

(c) the effectiveness of the program, including:

(i) any reduction in the number of emergency room visits or hospitalizations by inmates after release from a correctional facility;

(ii) any reduction in the number of inmates undergoing inpatient treatment after release

from a correctional facility;

(iii) any reduction in overdose rates and deaths of inmates after release from a correctional facility; and

(iv) any other costs or benefits as a result of the program.

[~~(4) If the waiver or state plan amendment described in Subsection (2) is approved, a county that is responsible for the cost of a qualified inmate's medical care shall provide the required matching funds to the state for:~~]

[~~(a) any costs to enroll the qualified inmate for the Medicaid coverage described in Subsection (2);~~]

[~~(b) any administrative fees for the Medicaid coverage described in Subsection (2); and~~]

[~~(c) the Medicaid coverage that is provided to the qualified inmate under Subsection (2).~~]

Section 13. Section **26B-3-224** is amended to read:

26B-3-224. Medicaid waiver for increased integrated health care reimbursement.

(1) As used in this section:

(a) "Integrated health care setting" means a health care or behavioral health care setting that provides integrated physical and behavioral health care services.

(b) "Local mental health authority" means a local mental health authority described in Section 17-43-301.

(2) The department shall develop a proposal to allow the state Medicaid program to reimburse a local mental health authority for covered physical health care services provided in an integrated health care setting to Medicaid eligible individuals.

(3) [~~Before December 31, 2022, the~~] The department shall apply for a Medicaid waiver or a state plan amendment with CMS to implement the proposal described in Subsection (2).

(4) If the waiver or state plan amendment described in Subsection (3) is approved, the department shall:

(a) implement the proposal described in Subsection (2); and

(b) while the waiver or state plan amendment is in effect, submit a report to the Health and Human Services Interim Committee each year before November 30 detailing:

(i) the number of patients served under the waiver or state plan amendment;

(ii) the cost of the waiver or state plan amendment; and

(iii) any benefits of the waiver or state plan amendment.

Section 14. Section **26B-3-226** is amended to read:

26B-3-226. Medicaid waiver for rural healthcare for chronic conditions.

(1) As used in this section:

(a) "Qualified condition" means:

(i) diabetes;

(ii) high blood pressure;

(iii) congestive heart failure;

(iv) asthma;

(v) obesity;

(vi) chronic obstructive pulmonary disease; or

(vii) chronic kidney disease.

(b) "Qualified enrollee" means an individual who:

(i) is enrolled in the Medicaid program;

(ii) has been diagnosed as having a qualified condition; and

(iii) is not enrolled in an accountable care organization.

(2) Before January 1, 2024, the department shall apply for a Medicaid waiver with [~~the Centers for Medicare and Medicaid Services~~] CMS to implement the coverage described in Subsection (3) for a three-year pilot program.

(3) If the waiver described in Subsection (2) is approved, the Medicaid program shall contract with a single entity to provide coordinated care for the following services to each qualified enrollee:

(a) a telemedicine platform for the qualified enrollee to use;

(b) an in-home initial visit to the qualified enrollee;

(c) daily remote monitoring of the qualified enrollee's qualified condition;

(d) all services in the qualified enrollee's language of choice;

(e) individual peer monitoring and coaching for the qualified enrollee;

(f) available access for the qualified enrollee to video-enabled consults and voice-enabled consults 24 hours a day, seven days a week;

(g) in-home biometric monitoring devices to monitor the qualified enrollee's qualified

condition; and

(h) at-home medication delivery to the qualified enrollee.

(4) The Medicaid program may not provide the coverage described in Subsection (3) until the waiver is approved.

(5) Each year the waiver is active, the department shall submit a report to the Health and Human Services Interim Committee before November 30 detailing:

(a) the number of patients served under the waiver;

(b) the cost of the waiver; and

(c) any benefits of the waiver, including an estimate of:

(i) the reductions in emergency room visits or hospitalizations;

(ii) the reductions in 30-day hospital readmissions for the same diagnosis;

(iii) the reductions in complications related to qualified conditions; and

(iv) any improvements in health outcomes from baseline assessments.

Section 15. Section **26B-3-401** is amended to read:

26B-3-401. Definitions.

As used in this part:

(1) (a) "Nursing care facility" means:

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

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

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

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

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

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

(i) the Utah State Developmental Center;

(ii) the Utah State Hospital;

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

(iv) a Utah State Veterans Home.

(2) "Patient day" means each calendar day in which an individual patient is admitted to

the nursing care facility during a calendar month, even if on a temporary leave of absence from the facility.

Section 16. Section **26B-3-403** is amended to read:

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

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

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

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

[~~(c)~~] (b) The department shall calculate the assessment imposed under Subsection (1)(a) by multiplying the total number of patient days of care provided to non-Medicare patients by the nursing care facility, as provided to the department pursuant to Subsection (3)(a), by the uniform rate established by the department pursuant to Subsection (1)(b).

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

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

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

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

(a) a report which includes:

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

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

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

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

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

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

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

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

Section 17. Section **26B-3-503** is amended to read:

26B-3-503. Assessment.

(1) An assessment is imposed on each private hospital:

[~~(a) beginning upon the later of CMS approval of:~~]

[~~(i) the health coverage improvement program waiver under Section 26B-3-207; and~~]

[~~(ii) the assessment under this part;~~]

[~~(b)~~] (a) in the amount designated in Sections 26B-3-506 and 26B-3-507; and

[~~(c)~~] (b) in accordance with Section 26B-3-504.

(2) Subject to Section 26B-3-505, the assessment imposed by this part is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26B-3-511 have been paid.

[~~(3) The first quarterly payment is not due until at least three months after the earlier of the effective dates of the coverage provided through:~~]

[~~(a) the health coverage improvement program;~~]

[~~(b) the enhancement waiver program; or~~]

[~~(c) the Medicaid waiver expansion.~~]

Section 18. Section **26B-3-504** is amended to read:

26B-3-504. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The collecting agent for the assessment imposed under Section 26B-3-503 is the department.

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

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

(b) audit records of a facility that:

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

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

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

(3) The department shall:

(a) administer the assessment in this part separately from the assessment in Part 7, Hospital Provider Assessment; and

(b) deposit assessments collected under this part into the Medicaid Expansion Fund [~~created by Section 26B-1-315~~].

Section 19. Section **26B-3-511** is amended to read:

26B-3-511. Outpatient upper payment limit supplemental payments.

(1) [~~Beginning on the effective date of the assessment imposed under this part, and for each subsequent fiscal year, the~~] The department shall [~~implement~~] administer an outpatient upper payment limit program for private hospitals that [~~shall supplement~~] supplements the reimbursement to private hospitals in accordance with Subsection (2).

(2) The division shall ensure that supplemental payment to Utah private hospitals under Subsection (1):

(a) does not exceed the positive upper payment limit gap; and

(b) is allocated based on the Medicaid state plan.

(3) The department shall use the same outpatient data to allocate the payments under Subsection (2) and to calculate the upper payment limit gap.

(4) The supplemental payments to private hospitals under Subsection (1) are payable for outpatient hospital services provided on or after the later of:

(a) July 1, 2016;

(b) the effective date of the Medicaid state plan amendment necessary to implement the payments under this section; or

(c) the effective date of the coverage provided through the health coverage improvement program waiver.

Section 20. Section **26B-3-512** is amended to read:

26B-3-512. Repeal of assessment.

(1) The assessment imposed by this part shall be repealed when:

(a) the executive director certifies that:

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

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

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

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

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

(b) this part is repealed in accordance with Section 63I-1-226.

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

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

(b) the department shall disburse money in the [~~special~~] Medicaid Expansion Fund in accordance with the requirements in Subsection 26B-1-315(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;

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

fiscal years; and

(d) any money remaining in the Medicaid Expansion Fund after the disbursements described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of the fiscal year that the assessment is suspended.

Section 21. Section **26B-3-605** is amended to read:

26B-3-605. Hospital share.

(1) The hospital share is[~~: (a) for the period from April 1, 2019, through June 30, 2020, $15,000,000; and (b) beginning July 1, 2020,~~] 100% of the state's net cost of [~~the qualified~~] Medicaid expansion, after deducting appropriate offsets and savings [~~expected~~] as a result of implementing [~~the qualified~~] Medicaid expansion, including:

[~~(i)~~] (a) savings from:

[~~(A)~~] (i) the Medicaid program's former Primary Care Network program;

[~~(B)~~] (ii) the health coverage improvement program[~~, as defined in Section 26B-3-207~~];

[~~(C)~~] (iii) the state portion of inpatient prison medical coverage;

[~~(D)~~] (iv) behavioral health coverage; and

[~~(E)~~] (v) county contributions to the non-federal share of Medicaid expenditures; and

[~~(ii)~~] (b) any funds appropriated to the Medicaid Expansion Fund.

(2) (a) [~~Beginning July 1, 2020, the~~] The hospital share is capped at no more than $15,000,000 annually.

(b) [~~Beginning July 1, 2020, the~~] The division shall prorate the cap specified in Subsection (2)(a) in any year in which [~~the qualified~~] Medicaid expansion is not in effect for the full fiscal year.

Section 22. Section **26B-3-607** is amended to read:

26B-3-607. Calculation of assessment.

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

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

(c) The division shall calculate the uniform assessment rate described in Subsection

(1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection 26B-3-606(1), by the sum of:

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

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

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

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

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as [~~follows: (a) for state fiscal year 2019, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and (b) for each subsequent state fiscal year,~~] the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 23. Section **26B-3-610** is amended to read:

26B-3-610. Hospital reimbursement.

(1) [~~If the qualified Medicaid expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to~~] To the extent allowed by law, the department shall in any contract with a Medicaid accountable care organization to implement Medicaid expansion include [~~in a contract to provide benefits under the qualified Medicaid expansion~~] a requirement that the Medicaid accountable care organization reimburse hospitals in the Medicaid accountable care organization's provider network at no less than the Medicaid fee-for-service rate.

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

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

Section 24. Section **26B-3-705** is amended to read:

26B-3-705. Calculation of assessment.

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

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

(c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to

all assessed hospitals.

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

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

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

(2) (a) For each state fiscal year, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the [~~Centers for Medicare and Medicaid Services'~~] CMS Healthcare Cost Report Information System file. The hospital's discharge data [~~will be derived as follows: (i) for state fiscal year 2013, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2009, and June 30, 2010; (ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2010, and June 30, 2011; (iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2011, and June 30, 2012; (iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2012, and June 30, 2013; and (v) for each subsequent state fiscal year,~~] is the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.

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

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

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

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

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

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

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

(3) Except as provided in Subsection (4), if a hospital is owned by an organization that

owns more than one hospital in the state:

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

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

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

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

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

Section 25. Section **26B-3-707** is amended to read:

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

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

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

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

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

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

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

(d) The division shall apply the same quality measures and penalties under this

Subsection (2) to new directed payments made to the University of Utah Hospital and Clinics.

Section 26. Section **26B-3-803** is amended to read:

26B-3-803. Calculation of assessment.

(1) The division shall calculate a uniform assessment per transport as described in this section.

(2) The assessment due from a given ambulance service provider equals the non-federal portion divided by total transports, multiplied by the number of transports for the ambulance service provider.

(3) The division shall apply any quarterly changes to the assessment rate, calculated as described in Subsection (2), uniformly to all assessed ambulance service providers.

(4) The assessment may not generate more than the total of:

(a) an annual amount of $20,000 to offset Medicaid administration expenses; and

(b) the non-federal portion.

(5) (a) For each state fiscal year, the division shall calculate total transports using [~~data from the Emergency Medical System as follows: (i) for state fiscal year 2016, the division shall use ambulance service provider transports during the 2014 calendar year; and (ii) for a fiscal year after 2016, the division shall use~~] ambulance service provider transports [~~during~~] data from the Emergency Medical System for the calendar year ending 18 months before the end of the fiscal year.

(b) If an ambulance service provider fails to submit transport information to the Emergency Medical System, the division may audit the ambulance service provider to determine the ambulance service provider's transports for a given fiscal year.

Section 27. Section **26B-3-1004** is amended to read:

26B-3-1004. Health insurance entity -- Duties related to state claims for Medicaid payment or recovery.

As a condition of doing business in the state, a health insurance entity shall:

(1) with respect to an individual who is eligible for, or is provided, medical assistance under the state plan, upon the request of the department, provide information to determine:

(a) during what period the individual, or the spouse or dependent of the individual, may be or may have been, covered by the health insurance entity; and

(b) the nature of the coverage that is or was provided by the health insurance entity

described in Subsection (1)(a), including the name, address, and identifying number of the plan;

(2) accept the state's right of recovery and the assignment to the state of any right of an individual to payment from a party for an item or service for which payment has been made under the state plan;

(3) respond within 60 days to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted no later than three years after the day on which the health care item or service is provided; [~~and~~]

(4) not deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to present proper documentation at the point-of-sale that is the basis for the claim, if:

(a) the claim is submitted no later than three years after the day on which the item or service is furnished; and

(b) any action by the department to enforce the rights of the state with respect to the claim is commenced no later than six years after the day on which the claim is submitted[~~.~~]; and

(5) not deny a claim submitted by the department for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payers rules.

Section 28. Section **63C-18-202** is amended to read:

63C-18-202. Commission established -- Members.

(1) There is created the Behavioral Health Crisis Response Commission, composed of the following members:

(a) the executive director of the Huntsman Mental Health Institute;

(b) the governor or the governor's designee;

(c) the director of the Office of Substance Use and Mental Health;

(d) one representative of the Office of the Attorney General, appointed by the attorney general;

(e) the executive director of the Department of Health and Human Services or the executive director's designee;

(f) one member of the public, appointed by the chair of the commission and approved

by the commission;

(g) two individuals who are mental or behavioral health clinicians licensed to practice in the state, appointed by the chair of the commission and approved by the commission, at least one of whom is an individual who:

(i) is licensed as a physician under:

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

(B) Title 58, Chapter 67b, Interstate Medical Licensure Compact; or

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

(ii) is board eligible for a psychiatry specialization recognized by the American Board of Medical Specialists or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(h) one individual who represents a county of the first or second class, appointed by the Utah Association of Counties;

(i) one individual who represents a county of the third, fourth, or fifth class, appointed by the Utah Association of Counties;

(j) one individual who represents the Utah Hospital Association, appointed by the chair of the commission;

(k) one individual who represents law enforcement, appointed by the chair of the commission;

(l) one individual who has lived with a mental health disorder, appointed by the chair of the commission;

(m) one individual who represents an integrated health care system that:

(i) is not affiliated with the chair of the commission; and

(ii) provides inpatient behavioral health services and emergency room services to individuals in the state;

(n) one individual who represents [~~an~~] a Medicaid accountable care organization, as defined in Section 26B-3-219, with a statewide membership base;

(o) one individual who represents 911 call centers and public safety answering points, appointed by the chair of the commission;

(p) one individual who represents Emergency Medical Services, appointed by the chair of the commission;

(q) one individual who represents the mobile wireless service provider industry, appointed by the chair of the commission;

(r) one individual who represents rural telecommunications providers, appointed by the chair of the commission;

(s) one individual who represents voice over internet protocol and land line providers, appointed by the chair of the commission;

(t) one individual who represents the Utah League of Cities and Towns, appointed by the Utah League of Cities and Towns; and

(u) three or six legislative members, the number of which shall be decided jointly by the speaker of the House of Representatives and the president of the Senate, appointed as follows:

(i) if the speaker of the House of Representatives and the president of the Senate jointly decide to appoint three legislative members to the commission, the speaker shall appoint one member of the House of Representatives, the president shall appoint one member of the Senate, and the speaker and the president shall jointly appoint one legislator from the minority party; or

(ii) if the speaker of the House of Representatives and the president of the Senate jointly decide to appoint six legislative members to the commission:

(A) the speaker of the House of Representatives shall appoint three members of the House of Representatives, no more than two of whom may be from the same political party; and

(B) the president of the Senate shall appoint three members of the Senate, no more than two of whom may be from the same political party.

(2) (a) Except as provided in Subsection (2)(d), the executive director of the Huntsman Mental Health Institute is the chair of the commission.

(b) The chair of the commission shall appoint a member of the commission to serve as the vice chair of the commission, with the approval of the commission.

(c) The chair of the commission shall set the agenda for each commission meeting.

(d) If the executive director of the Huntsman Mental Health Institute is not available to serve as the chair of the commission, the commission shall elect a chair from among the commission's members.

(3) (a) A majority of the members of the commission constitutes a quorum.

(b) The action of a majority of a quorum constitutes the action of the commission.

(4) (a) Except as provided in Subsection (4)(b), a member may not receive compensation, benefits, per diem, or travel expenses for the member's service on the commission.

(b) Compensation and expenses of a member who is a legislator are governed by Section 36-2-2 and Legislative Joint Rules, Title 5, Legislative Compensation and Expenses.

(5) The Office of the Attorney General shall provide staff support to the commission.

Section 29. **Repealer.**

This bill repeals:

Section **26B-3-138, Behavioral health delivery working group.**

Section 30. **Effective date.**

This bill takes effect on May 1, 2024.