LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: C. Williams ₵
₵ 02-21-24 9:40 AM ₵

H.B. 501
1st Sub. (Buff)

Representative James A. Dunnigan proposes the following substitute bill:

1 **HEALTH AMENDMENTS**
2 2024 GENERAL SESSION
3 STATE OF UTAH
4 **Chief Sponsor: James A. Dunnigan**
5 Senate Sponsor: Michael S. Kennedy
6
7 **LONG TITLE**
8 **General Description:**
9 This bill updates provisions related to health assistance.
10 **Highlighted Provisions:**
11 This bill:
12 ▸ amends or repeals obsolete Medicaid provisions and makes conforming changes;
13 ▸ requires the department to apply for a Medicaid waiver or amend an existing waiver
14 application related to qualified inmates in prison or jail; and
15 ▸ modifies provisions related to how a health insurance entity interacts with the
16 Medicaid program.
17 **Money Appropriated in this Bill:**
18 This bill appropriates in fiscal year 2025:
19 ▸ to Department of Health and Human Services - Integrated Health Care Services -
20 Medicaid Other Services as an ongoing appropriation:
21 • from the General Fund, $701,500
22 ▸ to Department of Health and Human Services - Integrated Health Care Services -
23 Non-Medicaid Behavioral Health Treatment and Crisis Response as an ongoing
24 appropriation:
25 • from the General Fund, $3,500,000

1st Sub. H.B. 501

26 **Other Special Clauses:**
27 None
28 **Utah Code Sections Affected:**
29 AMENDS:
30 **26B-1-316**, as last amended by Laws of Utah 2023, Chapter 495 and renumbered and
31 amended by Laws of Utah 2023, Chapter 305
32 **26B-1-332**, as renumbered and amended by Laws of Utah 2023, Chapter 305
33 **26B-3-108**, as last amended by Laws of Utah 2023, Chapter 466 and renumbered and
34 amended by Laws of Utah 2023, Chapter 306
35 **26B-3-110**, as renumbered and amended by Laws of Utah 2023, Chapter 306
36 **26B-3-111**, as renumbered and amended by Laws of Utah 2023, Chapter 306
37 **26B-3-112**, as renumbered and amended by Laws of Utah 2023, Chapter 306
38 **26B-3-126**, as renumbered and amended by Laws of Utah 2023, Chapter 306
39 **26B-3-136**, as renumbered and amended by Laws of Utah 2023, Chapter 306
40 **26B-3-201**, as renumbered and amended by Laws of Utah 2023, Chapter 306
41 **26B-3-203**, as renumbered and amended by Laws of Utah 2023, Chapter 306
42 **26B-3-205**, as renumbered and amended by Laws of Utah 2023, Chapter 306
43 **26B-3-217**, as renumbered and amended by Laws of Utah 2023, Chapter 306
44 **26B-3-224**, as renumbered and amended by Laws of Utah 2023, Chapter 306
45 **26B-3-226**, as enacted by Laws of Utah 2023, Chapter 336
46 **26B-3-401**, as renumbered and amended by Laws of Utah 2023, Chapter 306
47 **26B-3-403**, as renumbered and amended by Laws of Utah 2023, Chapter 306
48 **26B-3-503**, as renumbered and amended by Laws of Utah 2023, Chapter 306
49 **26B-3-504**, as renumbered and amended by Laws of Utah 2023, Chapter 306
50 **26B-3-511**, as renumbered and amended by Laws of Utah 2023, Chapter 306
51 **26B-3-512**, as renumbered and amended by Laws of Utah 2023, Chapter 306
52 **26B-3-605**, as renumbered and amended by Laws of Utah 2023, Chapter 306
53 **26B-3-607**, as renumbered and amended by Laws of Utah 2023, Chapter 306
54 **26B-3-610**, as renumbered and amended by Laws of Utah 2023, Chapter 306
55 **26B-3-705**, as renumbered and amended by Laws of Utah 2023, Chapter 306
56 **26B-3-707**, as last amended by Laws of Utah 2023, Chapter 495 and renumbered and

57 amended by Laws of Utah 2023, Chapter 306

58 **26B-3-803**, as renumbered and amended by Laws of Utah 2023, Chapter 306

59 **26B-3-1004**, as renumbered and amended by Laws of Utah 2023, Chapter 306

60 **63C-18-202**, as last amended by Laws of Utah 2023, Chapters 270, 329

61 REPEALS:

62 **26B-3-138**, as renumbered and amended by Laws of Utah 2023, Chapter 306

63

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

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

66 **26B-1-316. Hospital Provider Assessment Expendable Revenue Fund.**

67 (1) There is created an expendable special revenue fund known as the "Hospital

68 Provider Assessment Expendable Revenue Fund."

69 (2) The fund shall consist of:

70 (a) the assessments collected by the department under Chapter 3, Part 7, Hospital

71 Provider Assessment;

72 (b) any interest and penalties levied with the administration of Chapter 3, Part 7,

73 Hospital Provider Assessment; and

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

75 sources.

76 (3) Money in the fund shall be used:

77 (a) to support capitated rates consistent with Subsection 26B-3-705(1)(d) for

78 accountable care organizations as defined in Section 26B-3-701;

79 (b) to implement the quality strategies described in Subsection 26B-3-707(2), except

80 that the amount under this Subsection (3)(b) may not exceed $211,300 in each fiscal year; and

81 (c) to reimburse money collected by the division from a hospital, as defined in Section

82 26B-3-701, through a mistake made under Chapter 3, Part 7, Hospital Provider Assessment.

83 [~~(4) (a) Subject to Subsection (4)(b), for the fiscal year beginning July 1, 2019, and~~

84 ~~ending July 1, 2020, any fund balance in excess of the amount necessary to pay for the costs~~

85 ~~described in Subsection (3) shall be deposited into the General Fund.~~]

86 [~~(b) Subsection (4)(a) applies only to funds that were appropriated by the Legislature~~

87 ~~from the General Fund to the fund and the interest and penalties deposited into the fund under~~

88 ~~Subsection (2)(b).~~]

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

90 **26B-1-332. Nursing Care Facilities Provider Assessment Fund -- Creation --**

91 **Administration -- Uses.**

92 (1) There is created an expendable special revenue fund known as the "Nursing Care

93 Facilities Provider Assessment Fund" consisting of:

94 (a) [~~the~~] assessments collected by the department under Chapter 3, Part 4, Nursing

95 Care Facility Assessment;

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

97 Section 26B-2-222;

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

99 (d) any interest earned on the fund; and

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

101 Assessment.

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

103 (a) to the extent authorized by federal law, to obtain federal financial participation in

104 the Medicaid program;

105 (b) to provide the increased level of hospice reimbursement resulting from the nursing

106 care facilities assessment imposed under Section 26B-3-403;

107 (c) for the Medicaid program to make quality incentive payments to nursing care

108 facilities, subject to <u>CMS</u> approval of a Medicaid state plan amendment [~~to do so by the~~

109 ~~Centers for Medicare and Medicaid Services within the United States Department of Health~~

110 ~~and Human Services~~];

111 (d) to increase the rates paid before July 1, 2004, to nursing care facilities for providing

112 services pursuant to the Medicaid program; and

113 (e) for administrative expenses, if the administrative expenses for the fiscal year do not

114 exceed 3% of the money deposited into the fund during the fiscal year.

115 (3) The department may not spend the money in the fund to replace existing state

116 expenditures paid to nursing care facilities for providing services under the Medicaid program,

117 except for increased costs due to hospice reimbursement under Subsection (2)(b).

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

119 **26B-3-108. Administration of Medicaid program by department -- Reporting to**
120 **the Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility**
121 **standards -- Optional dental services costs and delivery -- Internal audits -- Health**
122 **opportunity accounts.**
123 (1) The department shall be the single state agency responsible for the administration
124 of the Medicaid program in connection with the United States Department of Health and
125 Human Services pursuant to Title XIX of the Social Security Act.
126 (2) (a) The department shall implement the Medicaid program through administrative
127 rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking
128 Act, the requirements of Title XIX, and applicable federal regulations.
129 (b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules
130 necessary to implement the program:
131 (i) the standards used by the department for determining eligibility for Medicaid
132 services;
133 (ii) the services and benefits to be covered by the Medicaid program;
134 (iii) reimbursement methodologies for providers under the Medicaid program; and
135 (iv) a requirement that:
136 (A) a person receiving Medicaid services shall participate in the electronic exchange of
137 clinical health records established in accordance with Section 26B-8-411 unless the individual
138 opts out of participation;
139 (B) prior to enrollment in the electronic exchange of clinical health records the enrollee
140 shall receive notice of enrollment in the electronic exchange of clinical health records and the
141 right to opt out of participation at any time; and
142 (C) [~~beginning July 1, 2012, when~~] when the program sends enrollment or renewal
143 information to the enrollee and when the enrollee logs onto the program's website, the enrollee
144 shall receive notice of the right to opt out of the electronic exchange of clinical health records.
145 (3) (a) The department shall, in accordance with Subsection (3)(b), report to the Social
146 Services Appropriations Subcommittee when the department:
147 (i) implements a change in the Medicaid State Plan;
148 (ii) initiates a new Medicaid waiver;
149 (iii) initiates an amendment to an existing Medicaid waiver;

150 (iv) applies for an extension of an application for a waiver or an existing Medicaid
151 waiver;
152 (v) applies for or receives approval for a change in any capitation rate within the
153 Medicaid program; or
154 (vi) initiates a rate change that requires public notice under state or federal law.
155 (b) The report required by Subsection (3)(a) shall:
156 (i) be submitted to the Social Services Appropriations Subcommittee prior to the
157 department implementing the proposed change; and
158 (ii) include:
159 (A) a description of the department's current practice or policy that the department is
160 proposing to change;
161 (B) an explanation of why the department is proposing the change;
162 (C) the proposed change in services or reimbursement, including a description of the
163 effect of the change;
164 (D) the effect of an increase or decrease in services or benefits on individuals and
165 families;
166 (E) the degree to which any proposed cut may result in cost-shifting to more expensive
167 services in health or human service programs; and
168 (F) the fiscal impact of the proposed change, including:
169 (I) the effect of the proposed change on current or future appropriations from the
170 Legislature to the department;
171 (II) the effect the proposed change may have on federal matching dollars received by
172 the state Medicaid program;
173 (III) any cost shifting or cost savings within the department's budget that may result
174 from the proposed change; and
175 (IV) identification of the funds that will be used for the proposed change, including any
176 transfer of funds within the department's budget.
177 (4) Any rules adopted by the department under Subsection (2) are subject to review and
178 reauthorization by the Legislature in accordance with Section 63G-3-502.
179 (5) The department may, in its discretion, contract with other qualified agencies for
180 services in connection with the administration of the Medicaid program, including:

181 (a) the determination of the eligibility of individuals for the program;
182 (b) recovery of overpayments; and
183 (c) consistent with Section 26B-3-1113, and to the extent permitted by law and quality
184 control services, enforcement of fraud and abuse laws.
185 (6) The department shall provide, by rule, disciplinary measures and sanctions for
186 Medicaid providers who fail to comply with the rules and procedures of the program, provided
187 that sanctions imposed administratively may not extend beyond:
188 (a) termination from the program;
189 (b) recovery of claim reimbursements incorrectly paid; and
190 (c) those specified in Section 1919 of Title XIX of the federal Social Security Act.
191 (7) (a) Funds collected as a result of a sanction imposed under Section 1919 of Title
192 XIX of the federal Social Security Act shall be deposited [~~in~~] into the General Fund as
193 dedicated credits to be used by the division in accordance with the requirements of Section
194 1919 of Title XIX of the federal Social Security Act.
195 (b) In accordance with Section 63J-1-602.2, sanctions collected under this Subsection
196 (7) are nonlapsing.
197 (8) (a) In determining whether an applicant or recipient is eligible for a service or
198 benefit under this part or Part 9, Utah Children's Health Insurance Program, the department
199 shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle
200 designated by the applicant or recipient.
201 (b) Before Subsection (8)(a) may be applied:
202 (i) the federal government shall:
203 (A) determine that Subsection (8)(a) may be implemented within the state's existing
204 public assistance-related waivers as of January 1, 1999;
205 (B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or
206 (C) determine that the state's waivers that permit dual eligibility determinations for
207 cash assistance and Medicaid are no longer valid; and
208 (ii) the department shall determine that Subsection (8)(a) can be implemented within
209 existing funding.
210 (9) (a) As used in this Subsection (9):
211 (i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as

212 defined in 42 U.S.C. Sec. 1382c(a)(1); and
213 (ii) "spend down" means an amount of income in excess of the allowable income
214 standard that shall be paid in cash to the department or incurred through the medical services
215 not paid by Medicaid.
216 (b) In determining whether an applicant or recipient who is aged, blind, or has a
217 disability is eligible for a service or benefit under this chapter, the department shall use 100%
218 of the federal poverty level as:
219 (i) the allowable income standard for eligibility for services or benefits; and
220 (ii) the allowable income standard for eligibility as a result of spend down.
221 (10) The department shall conduct internal audits of the Medicaid program.
222 [~~(11) (a) The department may apply for and, if approved, implement a demonstration~~
223 ~~program for health opportunity accounts, as provided for in 42 U.S.C. Sec. 1396u-8.~~]
224 [~~(b) A health opportunity account established under Subsection (11)(a) shall be an~~
225 ~~alternative to the existing benefits received by an individual eligible to receive Medicaid under~~
226 ~~this chapter.~~]
227 [~~(c) Subsection (11)(a) is not intended to expand the coverage of the Medicaid~~
228 ~~program.~~]
229 [~~(12)~~] (11) (a) (i) The department shall apply for, and if approved, implement an
230 amendment to the state plan under this Subsection [~~(12)~~] (11) for benefits for:
231 (A) medically needy pregnant women;
232 (B) medically needy children; and
233 (C) medically needy parents and caretaker relatives.
234 (ii) The department may implement the eligibility standards of Subsection [~~(12)(b)~~]
235 (11)(b) for eligibility determinations made on or after the date of the approval of the
236 amendment to the state plan.
237 (b) In determining whether an applicant is eligible for benefits described in Subsection
238 [~~(12)(a)(i)~~] (11)(a)(i), the department shall:
239 (i) disregard resources held in an account in [~~the~~] a savings plan created under Title
240 53B, Chapter 8a, Utah Educational Savings Plan, if the beneficiary of the account is:
241 (A) under the age of 26; and
242 (B) living with the account owner, as that term is defined in Section 53B-8a-102, or

243 temporarily absent from the residence of the account owner; and
244 (ii) include [~~the~~] withdrawals from an account in the Utah Educational Savings Plan as
245 resources for a benefit determination, if the [~~withdrawal was~~] withdrawals were not used for
246 qualified higher education costs as that term is defined in Section 53B-8a-102.5.
247 [~~(13)~~] (12) (a) The department may not deny or terminate eligibility for Medicaid
248 solely because an individual is:
249 (i) incarcerated; and
250 (ii) not an inmate as defined in Section 64-13-1.
251 (b) Subsection [~~(13)(a)~~] (12)(a) does not require the Medicaid program to provide
252 coverage for any services for an individual while the individual is incarcerated.
253 [~~(14)~~] (13) The department is a party to, and may intervene at any time in, any judicial
254 or administrative action:
255 (a) to which the Department of Workforce Services is a party; and
256 (b) that involves medical assistance under this chapter.
257 [~~(15)~~] (14) (a) The department may not deny or terminate eligibility for Medicaid
258 solely because a birth mother, as that term is defined in Section 78B-6-103, considers an
259 adoptive placement for the child or proceeds with an adoptive placement of the child.
260 (b) A health care provider, as that term is defined in Section 26B-3-126, may not
261 decline payment by Medicaid for covered health and medical services provided to a birth
262 mother, as that term is defined in Section 78B-6-103, who is enrolled in Utah's Medicaid
263 program and who considers an adoptive placement for the child or proceeds with an adoptive
264 placement of the child.
265 Section 4. Section **26B-3-110** is amended to read:
266 **26B-3-110. Copayments by recipients -- Employer sponsored plans.**
267 (1) The department shall selectively provide for enrollment fees, premiums,
268 deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and
269 parents, within the limitations of federal law and regulation.
270 (2) [~~Beginning May 1, 2006, within~~] Within appropriations by the Legislature and as a
271 means to increase health care coverage among the uninsured, the department shall take steps to
272 promote increased participation in employer sponsored health insurance, including:
273 (a) maximizing the health insurance premium subsidy provided under the state's 1115

274 demonstration waiver by:
275 (i) ensuring that state funds are matched by federal funds to the greatest extent
276 allowable; and
277 (ii) as the department determines appropriate, seeking federal approval to do one or
278 more of the following:
279 (A) eliminate or otherwise modify the annual enrollment fee;
280 (B) eliminate or otherwise modify the schedule used to determine the level of subsidy
281 provided to an enrollee each year;
282 (C) reduce the maximum number of participants allowable under the subsidy program;
283 or
284 (D) otherwise modify the program in a manner that promotes enrollment in employer
285 sponsored health insurance; and
286 (b) exploring the use of other options, including the development of a waiver under the
287 Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.
288 Section 5. Section **26B-3-111** is amended to read:
289 **26B-3-111. Income and resources from institutionalized spouses.**
290 (1) As used in this section:
291 (a) "Community spouse" means the spouse of an institutionalized spouse.
292 (b) (i) "Community spouse monthly income allowance" means an amount by which the
293 minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly
294 income otherwise available to the community spouse, determined without regard to the
295 allowance, except as provided in Subsection (1)(b)(ii).
296 (ii) If a court has entered an order against an institutionalized spouse for monthly
297 income for the support of the community spouse, the community spouse monthly income
298 allowance for the spouse may not be less than the amount of the monthly income so ordered.
299 (c) "Community spouse resource allowance" is the amount of combined resources that
300 are protected for a community spouse living in the community, which the division shall
301 establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
302 Rulemaking Act, based on the amounts established by the United States Department of Health
303 and Human Services.
304 (d) "Excess shelter allowance" for a community spouse means the amount by which the

305 sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case
306 of condominium or cooperative, required maintenance charge, for the community spouse's
307 principal residence and the spouse's actual expenses for electricity, natural gas, and water
308 utilities or, at the discretion of the department, the federal standard utility allowance under
309 SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection
310 (9).
311 (e) "Family member" means a minor dependent child, dependent parents, or dependent
312 sibling of the institutionalized spouse or community spouse who are residing with the
313 community spouse.
314 (f) (i) "Institutionalized spouse" means a person who is residing in a nursing facility
315 and is married to a spouse who is not in a nursing facility.
316 (ii) An "institutionalized spouse" does not include a person who is not likely to reside
317 in a nursing facility for at least 30 consecutive days.
318 (g) "Nursing care facility" means the same as that term is defined in Section
319 26B-2-201.
320 (2) The division shall comply with this section when determining eligibility for
321 medical assistance for an institutionalized spouse.
322 (3) [~~For services furnished during a calendar year beginning on or after January 1,~~
323 ~~1999, the~~] The community spouse resource allowance shall be increased by the division by an
324 amount as determined annually by CMS.
325 (4) The division shall compute, as of the beginning of the first continuous period of
326 institutionalization of the institutionalized spouse:
327 (a) the total value of the resources to the extent either the institutionalized spouse or
328 the community spouse has an ownership interest; and
329 (b) a spousal share, which is 1/2 of the resources described in Subsection (4)(a).
330 (5) At the request of an institutionalized spouse or a community spouse, at the
331 beginning of the first continuous period of institutionalization of the institutionalized spouse
332 and upon the receipt of relevant documentation of resources, the division shall promptly assess
333 and document the total value described in Subsection (4)(a) and shall provide a copy of that
334 assessment and documentation to each spouse and shall retain a copy of the assessment. When
335 the division provides a copy of the assessment, it shall include a notice stating that the spouse

336 may request a hearing under Subsection (11).
337 (6) When determining eligibility for medical assistance under this chapter:
338 (a) Except as provided in Subsection (6)(b), all resources held by either the
339 institutionalized spouse, community spouse, or both, are considered to be available to the
340 institutionalized spouse.
341 (b) Resources are considered to be available to the institutionalized spouse only to the
342 extent that the amount of those resources exceeds the community spouse resource allowance at
343 the time of application for medical assistance under this chapter.
344 (7) (a) The division may not find an institutionalized spouse to be ineligible for
345 medical assistance by reason of resources determined under Subsection (5) to be available for
346 the cost of care when:
347 (i) the institutionalized spouse has assigned to the state any rights to support from the
348 community spouse;
349 (ii) except as provided in Subsection (7)(b), the institutionalized spouse lacks the
350 ability to execute an assignment due to physical or mental impairment; or
351 (iii) the division determines that denial of medical assistance would cause an undue
352 burden.
353 (b) Subsection (7)(a)(ii) does not prevent the division from seeking a court order for an
354 assignment of support.
355 (8) During the continuous period in which an institutionalized spouse is in an
356 institution and after the month in which an institutionalized spouse is eligible for medical
357 assistance, the resources of the community spouse may not be considered to be available to the
358 institutionalized spouse.
359 (9) When an institutionalized spouse is determined to be eligible for medical
360 assistance, in determining the amount of the spouse's income that is to be applied monthly for
361 the cost of care in the nursing care facility, the division shall deduct from the spouse's monthly
362 income the following amounts in the following order:
363 (a) a personal needs allowance, the amount of which is determined by the division;
364 (b) a community spouse monthly income allowance, but only to the extent that the
365 income of the institutionalized spouse is made available to, or for the benefit of, the community
366 spouse;

367 (c) a family allowance for each family member, equal to at least 1/3 of the amount that
368 the amount described in Subsection (10)(a) exceeds the amount of the family member's
369 monthly income; and
370 (d) amounts for incurred expenses for the medical or remedial care for the
371 institutionalized spouse.
372 (10) The division shall establish a minimum monthly maintenance needs allowance for
373 each community spouse that includes:
374 (a) an amount established by the division by rule made in accordance with Title 63G,
375 Chapter 3, Utah Administrative Rulemaking Act, based on the amounts established by the
376 United States Department of Health and Human Services; and
377 (b) an excess shelter allowance.
378 (11) (a) An institutionalized spouse or a community spouse may request a hearing with
379 respect to the determinations described in Subsections (11)(e)(i) through (v) if an application
380 for medical assistance has been made on behalf of the institutionalized spouse.
381 (b) A hearing under this subsection regarding the community spouse resource
382 allowance shall be held by the division within 90 days from the date of the request for the
383 hearing.
384 (c) If either spouse establishes that the community spouse needs income, above the
385 level otherwise provided by the minimum monthly maintenance needs allowance, due to
386 exceptional circumstances resulting in significant financial duress, there shall be substituted,
387 for the minimum monthly maintenance needs allowance provided under Subsection (10), an
388 amount adequate to provide additional income as is necessary.
389 (d) If either spouse establishes that the community spouse resource allowance, in
390 relation to the amount of income generated by the allowance is inadequate to raise the
391 community spouse's income to the minimum monthly maintenance needs allowance, there shall
392 be substituted, for the community spouse resource allowance, an amount adequate to provide a
393 minimum monthly maintenance needs allowance.
394 (e) A hearing may be held under this subsection if either the institutionalized spouse or
395 community spouse is dissatisfied with a determination of:
396 (i) the community spouse monthly income allowance;
397 (ii) the amount of monthly income otherwise available to the community spouse;

398 (iii) the computation of the spousal share of resources under Subsection (4);
399 (iv) the attribution of resources under Subsection (6); or
400 (v) the determination of the community spouse resource allocation.
401 (12) (a) An institutionalized spouse may transfer an amount equal to the community
402 spouse resource allowance, but only to the extent the resources of the institutionalized spouse
403 are transferred to or for the sole benefit of the community spouse.
404 (b) The transfer under Subsection (12)(a) shall be made as soon as practicable after the
405 date of the initial determination of eligibility, taking into account the time necessary to obtain a
406 court order under Subsection (12)(c).
407 (c) Part 10, Medical Benefits Recovery, does not apply if a court has entered an order
408 against an institutionalized spouse for the support of the community spouse.
409 Section 6. Section **26B-3-112** is amended to read:
410 **26B-3-112. Maximizing use of premium assistance programs -- Utah's Premium**
411 **Partnership for Health Insurance.**
412 (1) (a) The department shall seek to maximize the use of Medicaid and Children's
413 Health Insurance Program funds for assistance in the purchase of private health insurance
414 coverage for Medicaid-eligible and non-Medicaid-eligible individuals.
415 (b) The department's efforts to expand the use of premium assistance shall:
416 (i) include, as necessary, seeking federal approval under all Medicaid and Children's
417 Health Insurance Program premium assistance provisions of federal law, including provisions
418 of PPACA;
419 (ii) give priority to, but not be limited to, expanding the state's Utah Premium
420 Partnership for Health Insurance [~~Program~~] program, including as required under Subsection
421 (2); and
422 (iii) encourage the enrollment of all individuals within a household in the same plan,
423 where possible, including enrollment in a plan that allows individuals within the household
424 transitioning out of Medicaid to retain the same network and benefits they had while enrolled
425 in Medicaid.
426 (2) The department shall seek federal approval of an amendment to the state's Utah
427 Premium Partnership for Health Insurance program to adjust the eligibility determination for
428 single adults and parents who have an offer of employer sponsored insurance. The amendment

429 shall:
430 (a) be within existing appropriations for the Utah Premium Partnership for Health
431 Insurance program; and
432 (b) provide that adults who are up to 200% of the federal poverty level are eligible for
433 premium subsidies in the Utah Premium Partnership for Health Insurance program.
434 (3) For the fiscal year 2020-21, the department shall seek authority to increase the
435 maximum premium subsidy per month for adults under the Utah Premium Partnership for
436 Health Insurance program to $300.
437 (4) [~~Beginning with the fiscal year 2021-22, and in each subsequent~~] In each fiscal
438 year, the department may increase premium subsidies for single adults and parents who have an
439 offer of employer-sponsored insurance to keep pace with the increase in insurance premium
440 costs, subject to appropriation of additional funding.
441 Section 7. Section **26B-3-126** is amended to read:
442 **26B-3-126. Patient notice of health care provider privacy practices.**
443 (1) (a) For purposes of this section:
444 (i) "Health care provider" means a health care provider as defined in Section
445 78B-3-403 who:
446 (A) receives payment for medical services from the Medicaid program established in
447 this chapter, or the Children's Health Insurance Program established in Section 26B-3-902; and
448 (B) submits a patient's personally identifiable information to the Medicaid eligibility
449 database or the Children's Health Insurance Program eligibility database.
450 (ii) "HIPAA" means 45 C.F.R. Parts 160, 162, and 164, Health Insurance Portability
451 and Accountability Act of 1996, as amended.
452 (b) [~~Beginning July 1, 2013, this~~] This section applies to the Medicaid program, the
453 Children's Health Insurance Program created in Section 26B-3-902, and a health care provider.
454 (2) A health care provider shall, as part of the notice of privacy practices required by
455 HIPAA, provide notice to the patient or the patient's personal representative that the health care
456 provider either has, or may submit, personally identifiable information about the patient to the
457 Medicaid eligibility database and the Children's Health Insurance Program eligibility database.
458 (3) The Medicaid program and the Children's Health Insurance Program may not give a
459 health care provider access to the Medicaid eligibility database or the Children's Health

460 Insurance Program eligibility database unless the health care provider's notice of privacy
461 practices complies with Subsection (2).
462 (4) The department may adopt an administrative rule to establish uniform language for
463 the state requirement regarding notice of privacy practices to patients required under
464 Subsection (2).
465 Section 8. Section **26B-3-136** is amended to read:
466 **26B-3-136. Children's Health Care Coverage Program.**
467 (1) As used in this section:
468 (a) "CHIP" means the Children's Health Insurance Program created in Section
469 26B-3-902.
470 (b) "Program" means the Children's Health Care Coverage Program created in
471 Subsection (2).
472 (2) (a) There is created the Children's Health Care Coverage Program within the
473 department.
474 (b) The purpose of the program is to:
475 (i) promote health insurance coverage for children in accordance with Section
476 26B-3-124;
477 (ii) conduct research regarding families who are eligible for Medicaid and CHIP to
478 determine awareness and understanding of available coverage;
479 (iii) analyze trends in disenrollment and identify reasons that families may not be
480 renewing enrollment, including any barriers in the process of renewing enrollment;
481 (iv) administer surveys to recently enrolled CHIP members, as defined in Section
482 26B-3-901, and children's Medicaid enrollees to identify:
483 (A) how the enrollees learned about coverage; and
484 (B) any barriers during the application process;
485 (v) develop promotional material regarding CHIP and children's Medicaid eligibility,
486 including outreach through social media, video production, and other media platforms;
487 (vi) identify ways that the eligibility website for enrollment in CHIP and children's
488 Medicaid can be redesigned to increase accessibility and enhance the user experience;
489 (vii) identify outreach opportunities, including partnerships with community
490 organizations including:

491 (A) schools;
492 (B) small businesses;
493 (C) unemployment centers;
494 (D) parent-teacher associations; and
495 (E) youth athlete clubs and associations; and
496 (viii) develop messaging to increase awareness of coverage options that are available
497 through the department.
498 (3) (a) The department may not delegate implementation of the program to a private
499 entity.
500 (b) Notwithstanding Subsection (3)(a), the department may contract with a media
501 agency to conduct the activities described in Subsection (2)(b)(iv) and (vii).
502 Section 9. Section **26B-3-201** is amended to read:
503 **26B-3-201. Independent foster care adolescents.**
504 (1) As used in this section, an "independent foster care adolescent" includes any
505 individual who reached 18 years old while in the custody of the department if the department
506 was the primary case manager, or a federally recognized Indian tribe.
507 (2) An independent foster care adolescent is eligible, when funds are available, for
508 Medicaid coverage until the individual reaches 21 years old.
509 [~~(3) Before July 1, 2006, the division shall submit a state Medicaid Plan amendment to~~
510 ~~CMS to provide medical coverage for independent foster care adolescents effective fiscal year~~
511 ~~2006-07.~~]
512 Section 10. Section **26B-3-203** is amended to read:
513 **26B-3-203. Base budget appropriations for Medicaid accountable care**
514 **organizations and behavioral health plans -- Forecast of behavioral health services cost.**
515 (1) As used in this section:
516 (a) "ACO" means [~~an~~] a Medicaid accountable care organization that contracts with the
517 state's Medicaid program for:
518 (i) physical health services; or
519 (ii) integrated physical and behavioral health services.
520 (b) "Base budget" means the same as that term is defined in legislative rule.
521 (c) "Behavioral health plan" means a managed care or [~~fee for service~~] fee-for-service

522 delivery system that contracts with or is operated by the department to provide behavioral
523 health services to Medicaid eligible individuals.
524 (d) "Behavioral health services" means mental health or substance use treatment or
525 services.
526 (e) "General Fund growth factor" means the amount determined by dividing the next
527 fiscal year ongoing General Fund revenue estimate by current fiscal year ongoing
528 appropriations from the General Fund.
529 (f) "Next fiscal year ongoing General Fund revenue estimate" means the next fiscal
530 year ongoing General Fund revenue estimate identified by the Executive Appropriations
531 Committee, in accordance with legislative rule, for use by the Office of the Legislative Fiscal
532 Analyst in preparing budget recommendations.
533 (g) "Member" means an enrollee.
534 [~~(g)~~] (h) "PMPM" means per-member-per-month funding.
535 (2) If the General Fund growth factor is less than 100%, the next fiscal year base
536 budget shall, subject to Subsection (5), include an appropriation to the department in an
537 amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health
538 plans equals the current fiscal year PMPM for the ACOs and behavioral health plans multiplied
539 by 100%.
540 (3) If the General Fund growth factor is greater than or equal to 100%, but less than
541 102%, the next fiscal year base budget shall, subject to Subsection (5), include an appropriation
542 to the department in an amount necessary to ensure that the next fiscal year PMPM for ACOs
543 and behavioral health plans equals the current fiscal year PMPM for the ACOs and behavioral
544 health plans multiplied by the General Fund growth factor.
545 (4) If the General Fund growth factor is greater than or equal to 102%, the next fiscal
546 year base budget shall, subject to Subsection (5), include an appropriation to the department in
547 an amount necessary to ensure that the next fiscal year PMPM for ACOs and behavioral health
548 plans is greater than or equal to the current fiscal year PMPM for the ACOs and behavioral
549 health plans multiplied by 102% and less than or equal to the current fiscal year PMPM for the
550 ACOs and behavioral health plans multiplied by the General Fund growth factor.
551 (5) The appropriations provided to the department for behavioral health plans under
552 this section shall be reduced by the amount contributed by counties in the current fiscal year for

553 behavioral health plans in accordance with Subsections 17-43-201(5)(k) and
554 17-43-301(6)(a)(x).
555 (6) In order for the department to estimate the impact of Subsections (2) through (4)
556 before identification of the next fiscal year ongoing General Fund revenue estimate, the
557 Governor's Office of Planning and Budget shall, in cooperation with the Office of the
558 Legislative Fiscal Analyst, develop an estimate of ongoing General Fund revenue for the next
559 fiscal year and provide the estimate to the department no later than November 1 of each year.
560 (7) The Office of the Legislative Fiscal Analyst shall include an estimate of the cost of
561 behavioral health services in any state Medicaid funding or savings forecast that is completed
562 in coordination with the department and the Governor's Office of Planning and Budget.
563 Section 11. Section **26B-3-205** is amended to read:
564 **26B-3-205. Long-term care insurance partnership.**
565 (1) As used in this section:
566 (a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec.
567 7702B(b).
568 (b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec.
569 1396p(b)(1)(C)(iii).
570 (c) "State plan amendment" means an amendment to the state Medicaid plan drafted by
571 the department in compliance with this section.
572 (2) [~~No later than July 1, 2014, the~~] The department shall seek federal approval of a
573 state plan amendment that creates a qualified long-term care insurance partnership.
574 (3) The department may make rules to comply with federal laws and regulations
575 relating to qualified long-term care insurance partnerships and qualified long-term care
576 insurance contracts.
577 Section 12. Section **26B-3-217** is amended to read:
578 **26B-3-217. Medicaid waiver for coverage of qualified inmates leaving prison or**
579 **jail.**
580 (1) As used in this section:
581 (a) "Correctional facility" means:
582 (i) a county jail;
583 [~~(ii) the Department of Corrections, created in Section 64-13-2; or~~]

584 [(iii)] (ii) a prison, penitentiary, or other institution operated by or under contract with
585 the Department of Corrections for the confinement of an offender, as defined in Section
586 64-13-1[.]; or
587 (iii) a facility for secure confinement of minors operated by the Division of Juvenile
588 Justice and Youth Services.
589 (b) "Limited Medicaid benefit" means:
590 (i) reentry case management services;
591 (ii) physical and behavioral health clinical services;
592 (iii) medications and medication administration;
593 (iv) medication-assisted treatment, including all United States Food and Drug
594 Administration approved medications, including coverage for counseling; and
595 (v) other services as determined by rule made in accordance with Title 63G, Chapter 3,
596 Utah Administrative Rulemaking Act.
597 (c) "Qualified inmate" means an individual who:
598 (i) is incarcerated in a correctional facility; and
599 (ii) is ineligible for Medicaid as a result of incarceration but would otherwise qualify
600 for Medicaid.
601 [(ii) has:]
602 [(A) a chronic physical or behavioral health condition;]
603 [(B) a mental illness, as defined in Section 26B-5-301; or]
604 [(C) an opioid use disorder.]
605 (2) [Before July 1, 2020] Subject to appropriation, before July 1, 2024, the division
606 shall apply for a Medicaid waiver [or a state plan amendment], or amend an existing Medicaid
607 waiver application, with CMS to offer a program to provide a limited Medicaid [coverage]
608 benefit to a qualified inmate for up to [30] 90 days immediately before the day on which the
609 qualified inmate is released from a correctional facility.
610 (3) (a) Savings to state and local funds that result from the use of federal funds
611 provided under this section shall be used in accordance with a reinvestment plan as mandated
612 by CMS.
613 (b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
614 department shall make rules for a participating county to establish a reinvestment plan

615 described in Subsection (3)(a).
616 [~~(3)~~] (4) If the waiver [~~or state plan amendment~~] or amended waiver described in
617 Subsection (2) is approved, the department shall report to the Health and Human Services
618 Interim Committee each year before November 30 while the waiver [~~or state plan amendment~~]
619 is in effect regarding:
620 (a) the number of qualified inmates served under the program;
621 (b) the cost of the program; and
622 (c) the effectiveness of the program, including:
623 (i) any reduction in the number of emergency room visits or hospitalizations by
624 inmates after release from a correctional facility;
625 (ii) any reduction in the number of inmates undergoing inpatient treatment after release
626 from a correctional facility;
627 (iii) any reduction in overdose rates and deaths of inmates after release from a
628 correctional facility; and
629 (iv) any other costs or benefits as a result of the program.
630 (5) Before July 1, 2024, the department shall apply for a Medicaid waiver with CMS to
631 offer housing services for an individual that was a qualified inmate within the previous 12
632 months.
633 (6) The department may elect to not apply for a Medicaid waiver or limit services
634 described in this section based on appropriation.
635 [~~(4) If the waiver or state plan amendment described in Subsection (2) is approved, a~~
636 ~~county that is responsible for the cost of a qualified inmate's medical care shall provide the~~
637 ~~required matching funds to the state for:~~]
638 [~~(a) any costs to enroll the qualified inmate for the Medicaid coverage described in~~
639 ~~Subsection (2);~~]
640 [~~(b) any administrative fees for the Medicaid coverage described in Subsection (2);~~
641 ~~and~~]
642 [~~(c) the Medicaid coverage that is provided to the qualified inmate under Subsection~~
643 ~~(2).~~]
644 Section 13. Section **26B-3-224** is amended to read:
645 **26B-3-224. Medicaid waiver for increased integrated health care reimbursement.**

646 (1) As used in this section:
647 (a) "Integrated health care setting" means a health care or behavioral health care setting
648 that provides integrated physical and behavioral health care services.
649 (b) "Local mental health authority" means a local mental health authority described in
650 Section 17-43-301.
651 (2) The department shall develop a proposal to allow the state Medicaid program to
652 reimburse a local mental health authority for covered physical health care services provided in
653 an integrated health care setting to Medicaid eligible individuals.
654 (3) [~~Before December 31, 2022, the~~] The department shall apply for a Medicaid waiver
655 or a state plan amendment with CMS to implement the proposal described in Subsection (2).
656 (4) If the waiver or state plan amendment described in Subsection (3) is approved, the
657 department shall:
658 (a) implement the proposal described in Subsection (2); and
659 (b) while the waiver or state plan amendment is in effect, submit a report to the Health
660 and Human Services Interim Committee each year before November 30 detailing:
661 (i) the number of patients served under the waiver or state plan amendment;
662 (ii) the cost of the waiver or state plan amendment; and
663 (iii) any benefits of the waiver or state plan amendment.
664 Section 14. Section **26B-3-226** is amended to read:
665 **26B-3-226. Medicaid waiver for rural healthcare for chronic conditions.**
666 (1) As used in this section:
667 (a) "Qualified condition" means:
668 (i) diabetes;
669 (ii) high blood pressure;
670 (iii) congestive heart failure;
671 (iv) asthma;
672 (v) obesity;
673 (vi) chronic obstructive pulmonary disease; or
674 (vii) chronic kidney disease.
675 (b) "Qualified enrollee" means an individual who:
676 (i) is enrolled in the Medicaid program;

677 (ii) has been diagnosed as having a qualified condition; and
678 (iii) is not enrolled in an accountable care organization.
679 (2) Before January 1, 2024, the department shall apply for a Medicaid waiver with [~~the~~
680 ~~Centers for Medicare and Medicaid Services~~] CMS to implement the coverage described in
681 Subsection (3) for a three-year pilot program.
682 (3) If the waiver described in Subsection (2) is approved, the Medicaid program shall
683 contract with a single entity to provide coordinated care for the following services to each
684 qualified enrollee:
685 (a) a telemedicine platform for the qualified enrollee to use;
686 (b) an in-home initial visit to the qualified enrollee;
687 (c) daily remote monitoring of the qualified enrollee's qualified condition;
688 (d) all services in the qualified enrollee's language of choice;
689 (e) individual peer monitoring and coaching for the qualified enrollee;
690 (f) available access for the qualified enrollee to video-enabled consults and
691 voice-enabled consults 24 hours a day, seven days a week;
692 (g) in-home biometric monitoring devices to monitor the qualified enrollee's qualified
693 condition; and
694 (h) at-home medication delivery to the qualified enrollee.
695 (4) The Medicaid program may not provide the coverage described in Subsection (3)
696 until the waiver is approved.
697 (5) Each year the waiver is active, the department shall submit a report to the Health
698 and Human Services Interim Committee before November 30 detailing:
699 (a) the number of patients served under the waiver;
700 (b) the cost of the waiver; and
701 (c) any benefits of the waiver, including an estimate of:
702 (i) the reductions in emergency room visits or hospitalizations;
703 (ii) the reductions in 30-day hospital readmissions for the same diagnosis;
704 (iii) the reductions in complications related to qualified conditions; and
705 (iv) any improvements in health outcomes from baseline assessments.
706 Section 15. Section **26B-3-401** is amended to read:
707 **26B-3-401. Definitions.**

708 As used in this part:
709 (1) (a) "Nursing care facility" means:
710 (i) a nursing care facility as defined in Section 26B-2-201;
711 (ii) [~~beginning January 1, 2006, a~~] a designated swing bed in:
712 (A) a general acute hospital as defined in Section 26B-2-201; and
713 (B) a critical access hospital which meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2)
714 (1998); and
715 (iii) an intermediate care facility for people with an intellectual disability that is
716 licensed under Section 26B-2-212.
717 (b) "Nursing care facility" does not include:
718 (i) the Utah State Developmental Center;
719 (ii) the Utah State Hospital;
720 (iii) a general acute hospital, specialty hospital, or small health care facility as those
721 terms are defined in Section 26B-2-201; or
722 (iv) a Utah State Veterans Home.
723 (2) "Patient day" means each calendar day in which an individual patient is admitted to
724 the nursing care facility during a calendar month, even if on a temporary leave of absence from
725 the facility.
726 Section 16. Section **26B-3-403** is amended to read:
727 **26B-3-403. Collection, remittance, and payment of nursing care facilities**
728 **assessment.**
729 (1) [~~(a) Beginning July 1, 2004, an~~] An assessment is imposed upon each nursing care
730 facility in the amount designated in Subsection (1)(c).
731 [~~(b)~~] (a) (i) The department shall establish by rule, a uniform rate per non-Medicare
732 patient day that may not exceed 6% of the total gross revenue for services provided to patients
733 of all nursing care facilities licensed in this state.
734 (ii) For purposes of Subsection (1)(b)(i), total revenue does not include charitable
735 contribution received by a nursing care facility.
736 [~~(c)~~] (b) The department shall calculate the assessment imposed under Subsection
737 (1)(a) by multiplying the total number of patient days of care provided to non-Medicare
738 patients by the nursing care facility, as provided to the department pursuant to Subsection

739 (3)(a), by the uniform rate established by the department pursuant to Subsection (1)(b).
740 (2) (a) The assessment imposed by this part is due and payable on a monthly basis on
741 or before the last day of the month next succeeding each monthly period.
742 (b) The collecting agent for this assessment shall be the department which is vested
743 with the administration and enforcement of this part, including the right to audit records of a
744 nursing care facility related to patient days of care for the facility.
745 (c) The department shall forward proceeds from the assessment imposed by this part to
746 the state treasurer for deposit in the expendable special revenue fund as specified in Section
747 26B-1-332.
748 (3) Each nursing care facility shall, on or before the end of the month next succeeding
749 each calendar monthly period, file with the department:
750 (a) a report which includes:
751 (i) the total number of patient days of care the facility provided to non-Medicare
752 patients during the preceding month;
753 (ii) the total gross revenue the facility earned as compensation for services provided to
754 patients during the preceding month; and
755 (iii) any other information required by the department; and
756 (b) a return for the monthly period, and shall remit with the return the assessment
757 required by this part to be paid for the period covered by the return.
758 (4) Each return shall contain information and be in the form the department prescribes
759 by rule.
760 (5) The assessment as computed in the return is an allowable cost for Medicaid
761 reimbursement purposes.
762 (6) The department may by rule, extend the time for making returns and paying the
763 assessment.
764 (7) Each nursing care facility that fails to pay any assessment required to be paid to the
765 state, within the time required by this part, or that fails to file a return as required by this part,
766 shall pay, in addition to the assessment, penalties and interest as provided in Section
767 26B-3-404.
768 Section 17. Section **26B-3-503** is amended to read:
769 **26B-3-503. Assessment.**

770 (1) An assessment is imposed on each private hospital:
771 [~~(a) beginning upon the later of CMS approval of:~~]
772 [~~(i) the health coverage improvement program waiver under Section 26B-3-207; and~~]
773 [~~(ii) the assessment under this part;~~]
774 [~~(b)~~] (a) in the amount designated in Sections 26B-3-506 and 26B-3-507; and
775 [~~(c)~~] (b) in accordance with Section 26B-3-504.
776 (2) Subject to Section 26B-3-505, the assessment imposed by this part is due and
777 payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental
778 payments under Section 26B-3-511 have been paid.
779 [~~(3) The first quarterly payment is not due until at least three months after the earlier of~~
780 ~~the effective dates of the coverage provided through:~~]
781 [~~(a) the health coverage improvement program;~~]
782 [~~(b) the enhancement waiver program; or~~]
783 [~~(c) the Medicaid waiver expansion.~~]
784 Section 18. Section **26B-3-504** is amended to read:
785 **26B-3-504. Collection of assessment -- Deposit of revenue -- Rulemaking.**
786 (1) The collecting agent for the assessment imposed under Section 26B-3-503 is the
787 department.
788 (2) The department is vested with the administration and enforcement of this part, and
789 may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
790 Act, necessary to:
791 (a) collect the assessment, intergovernmental transfers, and penalties imposed under
792 this part;
793 (b) audit records of a facility that:
794 (i) is subject to the assessment imposed by this part; and
795 (ii) does not file a Medicare cost report; and
796 (c) select a report similar to the Medicare cost report if Medicare no longer uses a
797 Medicare cost report.
798 (3) The department shall:
799 (a) administer the assessment in this part separately from the assessment in Part 7,
800 Hospital Provider Assessment; and

801 (b) deposit assessments collected under this part into the Medicaid Expansion Fund
802 [~~created by Section 26B-1-315~~].
803 Section 19. Section **26B-3-511** is amended to read:
804 **26B-3-511. Outpatient upper payment limit supplemental payments.**
805 (1) [~~Beginning on the effective date of the assessment imposed under this part, and for~~
806 ~~each subsequent fiscal year, the~~] The department shall [~~implement~~] administer an outpatient
807 upper payment limit program for private hospitals that [~~shall supplement~~] supplements the
808 reimbursement to private hospitals in accordance with Subsection (2).
809 (2) The division shall ensure that supplemental payment to Utah private hospitals
810 under Subsection (1):
811 (a) does not exceed the positive upper payment limit gap; and
812 (b) is allocated based on the Medicaid state plan.
813 (3) The department shall use the same outpatient data to allocate the payments under
814 Subsection (2) and to calculate the upper payment limit gap.
815 (4) The supplemental payments to private hospitals under Subsection (1) are payable
816 for outpatient hospital services provided on or after the later of:
817 (a) July 1, 2016;
818 (b) the effective date of the Medicaid state plan amendment necessary to implement the
819 payments under this section; or
820 (c) the effective date of the coverage provided through the health coverage
821 improvement program waiver.
822 Section 20. Section **26B-3-512** is amended to read:
823 **26B-3-512. Repeal of assessment.**
824 (1) The assessment imposed by this part shall be repealed when:
825 (a) the executive director certifies that:
826 (i) action by Congress is in effect that disqualifies the assessment imposed by this part
827 from counting toward state Medicaid funds available to be used to determine the amount of
828 federal financial participation;
829 (ii) a decision, enactment, or other determination by the Legislature or by any court,
830 officer, department, or agency of the state, or of the federal government, is in effect that:
831 (A) disqualifies the assessment from counting toward state Medicaid funds available to

832 be used to determine federal financial participation for Medicaid matching funds; or
833 (B) creates for any reason a failure of the state to use the assessments for at least one of
834 the Medicaid programs described in this part; or
835 (iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient
836 payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1,
837 2015; or
838 (b) this part is repealed in accordance with Section 63I-1-226.
839 (2) If the assessment is repealed under Subsection (1):
840 (a) the division may not collect any assessment or intergovernmental transfer under this
841 part;
842 (b) the department shall disburse money in the [~~special~~] Medicaid Expansion Fund in
843 accordance with the requirements in Subsection 26B-1-315(4), to the extent federal matching is
844 not reduced by CMS due to the repeal of the assessment;
845 (c) any money remaining in the Medicaid Expansion Fund after the disbursement
846 described in Subsection (2)(b) that was derived from assessments imposed by this part shall be
847 refunded to the hospitals in proportion to the amount paid by each hospital for the last three
848 fiscal years; and
849 (d) any money remaining in the Medicaid Expansion Fund after the disbursements
850 described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of
851 the fiscal year that the assessment is suspended.
852 Section 21. Section **26B-3-605** is amended to read:
853 **26B-3-605. Hospital share.**
854 (1) The hospital share is[~~: (a) for the period from April 1, 2019, through June 30, 2020,~~
855 ~~$15,000,000; and (b) beginning July 1, 2020,~~] 100% of the state's net cost of [~~the qualified~~]
856 Medicaid expansion, after deducting appropriate offsets and savings [~~expected~~] as a result of
857 implementing [~~the qualified~~] Medicaid expansion, including:
858 [~~(i)~~] (a) savings from:
859 [~~(A)~~] (i) the Medicaid program's former Primary Care Network program;
860 [~~(B)~~] (ii) the health coverage improvement program[~~, as defined in Section~~
861 ~~26B-3-207~~];
862 [~~(C)~~] (iii) the state portion of inpatient prison medical coverage;

863 [~~(D)~~] (iv) behavioral health coverage; and
864 [~~(E)~~] (v) county contributions to the non-federal share of Medicaid expenditures; and
865 [~~(ii)~~] (b) any funds appropriated to the Medicaid Expansion Fund.
866 (2) (a) [~~Beginning July 1, 2020, the~~] The hospital share is capped at no more than
867 $15,000,000 annually.
868 (b) [~~Beginning July 1, 2020, the~~] The division shall prorate the cap specified in
869 Subsection (2)(a) in any year in which [~~the qualified~~] Medicaid expansion is not in effect for
870 the full fiscal year.
871 Section 22. Section **26B-3-607** is amended to read:
872 **26B-3-607. Calculation of assessment.**
873 (1) (a) Except as provided in Subsection (1)(b), each private hospital shall pay an
874 annual assessment due on the last day of each quarter in an amount calculated by the division at
875 a uniform assessment rate for each hospital discharge, in accordance with this section.
876 (b) A private teaching hospital with more than 425 beds and more than 60 residents
877 shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).
878 (c) The division shall calculate the uniform assessment rate described in Subsection
879 (1)(a) by dividing the hospital share for assessed private hospitals, as described in Subsection
880 26B-3-606(1), by the sum of:
881 (i) the total number of discharges for assessed private hospitals that are not a private
882 teaching hospital; and
883 (ii) 2.5 times the number of discharges for a private teaching hospital, described in
884 Subsection (1)(b).
885 (d) The division may make rules in accordance with Title 63G, Chapter 3, Utah
886 Administrative Rulemaking Act, to adjust the formula described in Subsection (1)(c) to address
887 unforeseen circumstances in the administration of the assessment under this part.
888 (e) The division shall apply any quarterly changes to the uniform assessment rate
889 uniformly to all assessed private hospitals.
890 (2) Except as provided in Subsection (3), for each state fiscal year, the division shall
891 determine a hospital's discharges as [~~follows: (a) for state fiscal year 2019, the hospital's cost~~
892 ~~report data for the hospital's fiscal year ending between July 1, 2015, and June 30, 2016; and~~
893 ~~(b) for each subsequent state fiscal year,~~] the hospital's cost report data for the hospital's fiscal

894 year that ended in the state fiscal year two years before the assessment fiscal year.
895 (3) (a) If a hospital's fiscal year Medicare cost report is not contained in the [~~Centers~~
896 ~~for Medicare and Medicaid Services'~~] CMS Healthcare Cost Report Information System file:
897 (i) the hospital shall submit to the division a copy of the hospital's Medicare cost report
898 applicable to the assessment year; and
899 (ii) the division shall determine the hospital's discharges.
900 (b) If a hospital is not certified by the Medicare program and is not required to file a
901 Medicare cost report:
902 (i) the hospital shall submit to the division the hospital's applicable fiscal year
903 discharges with supporting documentation;
904 (ii) the division shall determine the hospital's discharges from the information
905 submitted under Subsection (3)(b)(i); and
906 (iii) if the hospital fails to submit discharge information, the division shall audit the
907 hospital's records and may impose a penalty equal to 5% of the calculated assessment.
908 (4) Except as provided in Subsection (5), if a hospital is owned by an organization that
909 owns more than one hospital in the state:
910 (a) the division shall calculate the assessment for each hospital separately; and
911 (b) each separate hospital shall pay the assessment imposed by this part.
912 (5) If multiple hospitals use the same Medicaid provider number:
913 (a) the department shall calculate the assessment in the aggregate for the hospitals
914 using the same Medicaid provider number; and
915 (b) the hospitals may pay the assessment in the aggregate.
916 Section 23. Section **26B-3-610** is amended to read:
917 **26B-3-610. Hospital reimbursement.**
918 (1) [~~If the qualified Medicaid expansion is implemented by contracting with a~~
919 ~~Medicaid accountable care organization, the department shall, to~~] To the extent allowed by
920 law, the department shall in any contract with a Medicaid accountable care organization to
921 implement Medicaid expansion include [~~in a contract to provide benefits under the qualified~~
922 ~~Medicaid expansion~~] a requirement that the Medicaid accountable care organization reimburse
923 hospitals in the Medicaid accountable care organization's provider network at no less than the
924 Medicaid fee-for-service rate.

925 (2) [~~If the qualified~~] Where the department implements Medicaid expansion [~~is~~
926 ~~implemented by the department~~] as a fee-for-service program, the department shall reimburse
927 hospitals at no less than the Medicaid fee-for-service rate.
928 (3) Nothing in this section prohibits the department or a Medicaid accountable care
929 organization from paying a rate that exceeds the Medicaid fee-for-service rate.
930 Section 24. Section **26B-3-705** is amended to read:
931 **26B-3-705. Calculation of assessment.**
932 (1) (a) An annual assessment is payable on a quarterly basis for each hospital in an
933 amount calculated at a uniform assessment rate for each hospital discharge, in accordance with
934 this section.
935 (b) The uniform assessment rate shall be determined using the total number of hospital
936 discharges for assessed hospitals divided into the total non-federal portion in an amount
937 consistent with Section 26B-3-707 that is needed to support capitated rates for Medicaid
938 accountable care organizations for purposes of hospital services provided to Medicaid
939 enrollees.
940 (c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
941 all assessed hospitals.
942 (d) The annual uniform assessment rate may not generate more than:
943 (i) $1,000,000 to offset Medicaid mandatory expenditures; and
944 (ii) the non-federal share to seed amounts needed to support capitated rates for
945 Medicaid accountable care organizations as provided for in Subsection (1)(b).
946 (2) (a) For each state fiscal year, discharges shall be determined using the data from
947 each hospital's Medicare Cost Report contained in the [~~Centers for Medicare and Medicaid~~
948 ~~Services'~~] CMS Healthcare Cost Report Information System file. The hospital's discharge data
949 [~~will be derived as follows: (i) for state fiscal year 2013, the hospital's cost report data for the~~
950 ~~hospital's fiscal year ending between July 1, 2009, and June 30, 2010; (ii) for state fiscal year~~
951 ~~2014, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2010,~~
952 ~~and June 30, 2011; (iii) for state fiscal year 2015, the hospital's cost report data for the~~
953 ~~hospital's fiscal year ending between July 1, 2011, and June 30, 2012; (iv) for state fiscal year~~
954 ~~2016, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2012,~~
955 ~~and June 30, 2013; and (v) for each subsequent state fiscal year,~~] is the hospital's cost report

956 data for the hospital's fiscal year that ended in the state fiscal year two years prior to the
957 assessment fiscal year.
958 (b) If a hospital's fiscal year Medicare Cost Report is not contained in the [~~Centers for~~
959 ~~Medicare and Medicaid Services'~~] CMS Healthcare Cost Report Information System file:
960 (i) the hospital shall submit to the division a copy of the hospital's Medicare Cost
961 Report applicable to the assessment year; and
962 (ii) the division shall determine the hospital's discharges.
963 (c) If a hospital is not certified by the Medicare program and is not required to file a
964 Medicare Cost Report:
965 (i) the hospital shall submit to the division its applicable fiscal year discharges with
966 supporting documentation;
967 (ii) the division shall determine the hospital's discharges from the information
968 submitted under Subsection (2)(c)(i); and
969 (iii) the failure to submit discharge information shall result in an audit of the hospital's
970 records and a penalty equal to 5% of the calculated assessment.
971 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
972 owns more than one hospital in the state:
973 (a) the assessment for each hospital shall be separately calculated by the department;
974 and
975 (b) each separate hospital shall pay the assessment imposed by this part.
976 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the
977 same Medicaid provider number:
978 (a) the department shall calculate the assessment in the aggregate for the hospitals
979 using the same Medicaid provider number; and
980 (b) the hospitals may pay the assessment in the aggregate.
981 Section 25. Section **26B-3-707** is amended to read:
982 **26B-3-707. Medicaid hospital adjustment under Medicaid accountable care**
983 **organization rates.**
984 (1) To preserve and improve access to hospital services, the division shall incorporate
985 into the Medicaid accountable care organization rate structure calculation consistent with the
986 certified actuarial rate range:

987 (a) $154,000,000 to be allocated toward the hospital inpatient directed payments for the
988 Medicaid eligibility categories covered in Utah before January 1, 2019; and
989 (b) an amount equal to the difference between payments made to hospitals by Medicaid
990 accountable care organizations for the Medicaid eligibility categories covered in Utah, based on
991 submitted encounter data, and the maximum amount that could be paid for those services, to be
992 used for directed payments to hospitals for inpatient and outpatient services.
993 (2) (a) To preserve and improve the quality of inpatient and outpatient hospital services
994 authorized under Subsection (1)(b), the division shall amend its quality strategies required by
995 42 C.F.R. Sec. 438.340 to include quality measures selected from the CMS hospital quality
996 improvement programs.
997 (b) To better address the unique needs of rural and specialty hospitals, the division may
998 adopt different quality standards for rural and specialty hospitals.
999 (c) The division shall make rules in accordance with Title 63G, Chapter 3, Utah
1000 Administrative Rulemaking Act, to adopt the selected quality measures and prescribe penalties
1001 for not meeting the quality standards that are established by the division by rule.
1002 (d) The division shall apply the same quality measures and penalties under this
1003 Subsection (2) to new directed payments made to the University of Utah Hospital and Clinics.
1004 Section 26. Section **26B-3-803** is amended to read:
1005 **26B-3-803. Calculation of assessment.**
1006 (1) The division shall calculate a uniform assessment per transport as described in this
1007 section.
1008 (2) The assessment due from a given ambulance service provider equals the
1009 non-federal portion divided by total transports, multiplied by the number of transports for the
1010 ambulance service provider.
1011 (3) The division shall apply any quarterly changes to the assessment rate, calculated as
1012 described in Subsection (2), uniformly to all assessed ambulance service providers.
1013 (4) The assessment may not generate more than the total of:
1014 (a) an annual amount of $20,000 to offset Medicaid administration expenses; and
1015 (b) the non-federal portion.
1016 (5) (a) For each state fiscal year, the division shall calculate total transports using [~~data~~
1017 ~~from the Emergency Medical System as follows: (i) for state fiscal year 2016, the division shall~~

1018 ~~use ambulance service provider transports during the 2014 calendar year; and (ii) for a fiscal~~
1019 ~~year after 2016, the division shall use~~] ambulance service provider transports [~~during~~] data
1020 from the Emergency Medical System for the calendar year ending 18 months before the end of
1021 the fiscal year.
1022 (b) If an ambulance service provider fails to submit transport information to the
1023 Emergency Medical System, the division may audit the ambulance service provider to
1024 determine the ambulance service provider's transports for a given fiscal year.
1025 Section 27. Section **26B-3-1004** is amended to read:
1026 **26B-3-1004. Health insurance entity -- Duties related to state claims for Medicaid**
1027 **payment or recovery.**
1028 (1) As a condition of doing business in the state, a health insurance entity shall:
1029 [~~(1)~~] (a) with respect to an individual who is eligible for, or is provided, medical
1030 assistance under the state plan, upon the request of the department, provide information to
1031 determine:
1032 [~~(a)~~] (i) during what period the individual, or the spouse or dependent of the individual,
1033 may be or may have been, covered by the health insurance entity; and
1034 [~~(b)~~] (ii) the nature of the coverage that is or was provided by the health insurance
1035 entity described in Subsection (1)(a), including the name, address, and identifying number of
1036 the plan;
1037 [~~(2)~~] (b) accept the state's right of recovery and the assignment to the state of any right
1038 of an individual to payment from a party for an item or service for which payment has been
1039 made under the state plan;
1040 [~~(3)~~] (c) respond within 60 days to any inquiry by the department regarding a claim for
1041 payment for any health care item or service that is submitted no later than three years after the
1042 day on which the health care item or service is provided; [~~and~~]
1043 [~~(4)~~] (d) not deny a claim submitted by the department solely on the basis of the date of
1044 submission of the claim, the type or format of the claim form, or failure to present proper
1045 documentation at the point-of-sale that is the basis for the claim, if:
1046 [~~(a)~~] (i) the claim is submitted no later than three years after the day on which the item
1047 or service is furnished; and
1048 [~~(b)~~] (ii) any action by the department to enforce the rights of the state with respect to

1049 the claim is commenced no later than six years after the day on which the claim is submitted[.];
1050 and
1051 (e) not deny a claim submitted by the department or the department's contractor for an
1052 item or service solely on the basis that such item or service did not receive prior authorization
1053 under the third-party payer's rules.
1054 (2) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
1055 department shall make rules that encourage health care providers to seek prior authorization
1056 when necessary from a health insurance entity that is the primary payer before seeking
1057 third-party liability through Medicaid.
1058 Section 28. Section **63C-18-202** is amended to read:
1059 **63C-18-202. Commission established -- Members.**
1060 (1) There is created the Behavioral Health Crisis Response Commission, composed of
1061 the following members:
1062 (a) the executive director of the Huntsman Mental Health Institute;
1063 (b) the governor or the governor's designee;
1064 (c) the director of the Office of Substance Use and Mental Health;
1065 (d) one representative of the Office of the Attorney General, appointed by the attorney
1066 general;
1067 (e) the executive director of the Department of Health and Human Services or the
1068 executive director's designee;
1069 (f) one member of the public, appointed by the chair of the commission and approved
1070 by the commission;
1071 (g) two individuals who are mental or behavioral health clinicians licensed to practice
1072 in the state, appointed by the chair of the commission and approved by the commission, at least
1073 one of whom is an individual who:
1074 (i) is licensed as a physician under:
1075 (A) Title 58, Chapter 67, Utah Medical Practice Act;
1076 (B) Title 58, Chapter 67b, Interstate Medical Licensure Compact; or
1077 (C) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act; and
1078 (ii) is board eligible for a psychiatry specialization recognized by the American Board
1079 of Medical Specialists or the American Osteopathic Association's Bureau of Osteopathic

1080 Specialists;
1081 (h) one individual who represents a county of the first or second class, appointed by the
1082 Utah Association of Counties;
1083 (i) one individual who represents a county of the third, fourth, or fifth class, appointed
1084 by the Utah Association of Counties;
1085 (j) one individual who represents the Utah Hospital Association, appointed by the chair
1086 of the commission;
1087 (k) one individual who represents law enforcement, appointed by the chair of the
1088 commission;
1089 (l) one individual who has lived with a mental health disorder, appointed by the chair
1090 of the commission;
1091 (m) one individual who represents an integrated health care system that:
1092 (i) is not affiliated with the chair of the commission; and
1093 (ii) provides inpatient behavioral health services and emergency room services to
1094 individuals in the state;
1095 (n) one individual who represents [~~an~~] a Medicaid accountable care organization, as
1096 defined in Section 26B-3-219, with a statewide membership base;
1097 (o) one individual who represents 911 call centers and public safety answering points,
1098 appointed by the chair of the commission;
1099 (p) one individual who represents Emergency Medical Services, appointed by the chair
1100 of the commission;
1101 (q) one individual who represents the mobile wireless service provider industry,
1102 appointed by the chair of the commission;
1103 (r) one individual who represents rural telecommunications providers, appointed by the
1104 chair of the commission;
1105 (s) one individual who represents voice over internet protocol and land line providers,
1106 appointed by the chair of the commission;
1107 (t) one individual who represents the Utah League of Cities and Towns, appointed by
1108 the Utah League of Cities and Towns; and
1109 (u) three or six legislative members, the number of which shall be decided jointly by
1110 the speaker of the House of Representatives and the president of the Senate, appointed as

1111 follows:

1112 (i) if the speaker of the House of Representatives and the president of the Senate jointly
1113 decide to appoint three legislative members to the commission, the speaker shall appoint one
1114 member of the House of Representatives, the president shall appoint one member of the Senate,
1115 and the speaker and the president shall jointly appoint one legislator from the minority party; or

1116 (ii) if the speaker of the House of Representatives and the president of the Senate
1117 jointly decide to appoint six legislative members to the commission:

1118 (A) the speaker of the House of Representatives shall appoint three members of the
1119 House of Representatives, no more than two of whom may be from the same political party;
1120 and

1121 (B) the president of the Senate shall appoint three members of the Senate, no more than
1122 two of whom may be from the same political party.

1123 (2) (a) Except as provided in Subsection (2)(d), the executive director of the Huntsman
1124 Mental Health Institute is the chair of the commission.

1125 (b) The chair of the commission shall appoint a member of the commission to serve as
1126 the vice chair of the commission, with the approval of the commission.

1127 (c) The chair of the commission shall set the agenda for each commission meeting.

1128 (d) If the executive director of the Huntsman Mental Health Institute is not available to
1129 serve as the chair of the commission, the commission shall elect a chair from among the
1130 commission's members.

1131 (3) (a) A majority of the members of the commission constitutes a quorum.

1132 (b) The action of a majority of a quorum constitutes the action of the commission.

1133 (4) (a) Except as provided in Subsection (4)(b), a member may not receive
1134 compensation, benefits, per diem, or travel expenses for the member's service on the
1135 commission.

1136 (b) Compensation and expenses of a member who is a legislator are governed by
1137 Section 36-2-2 and Legislative Joint Rules, Title 5, Legislative Compensation and Expenses.

1138 (5) The Office of the Attorney General shall provide staff support to the commission.

1139 Section 29. **Repealer.**

1140 This bill repeals:

1141 Section **26B-3-138, Behavioral health delivery working group.**

1142 Section 30. **FY 2025 Appropriation.**
1143 The following sums of money are appropriated for the fiscal year beginning July 1,
1144 2024, and ending June 30, 2025. These are additions to amounts previously appropriated for
1145 fiscal year 2025.
1146 Subsection 30(a). **Operating and Capital Budgets.**
1147 Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, the
1148 Legislature appropriates the following sums of money from the funds or accounts indicated for
1149 the use and support of the government of the state of Utah.

1150	ITEM 1	To Department of Health and Human Services - Integrated Health Care Services		
1151		From General Fund		$701,500
1152		Schedule of Programs:		
1153		Medicaid Other Services	$701,500	

1154 The Legislature intends that the Department of Health and Human Services use the
1155 appropriation to increase primary care provider rates in Medicaid by 2.12%.

1156	ITEM 2	To Department of Health and Human Services - Integrated Health Care Services		
1157		From General Fund		$3,500,000
1158		Schedule of Programs:		
1159		Non-Medicaid Behavioral Health Treatment and Crisis Response	$3,500,000	

1160 The Legislature intends that the Office of Substance Use and Mental Health pass through the
1161 appropriation provided under this item to each local substance abuse and mental health
1162 authority to pay county contributions to the nonfederal share of Medicaid expenditures.
1163 Section 31. **Effective date.**
1164 This bill takes effect on May 1, 2024.