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H.B. 436
1st Sub. (Buff)

Representative James A. Dunnigan proposes the following substitute bill:

HEALTH AND HUMAN SERVICES AMENDMENTS

2020 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Allen M. Christensen

LONG TITLE

General Description:

This bill amends provisions related to health and human services.

Highlighted Provisions:

This bill:

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

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a coordination clause.

Utah Code Sections Affected:

AMENDS:

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

26-18-2.6, as last amended by Laws of Utah 2017, Chapter 22

26-18-3.1, as last amended by Laws of Utah 2019, Chapter 1

26-18-3.8, as last amended by Laws of Utah 2013, Chapter 137

26-18-3.9, as last amended by Laws of Utah 2019, Chapter 1

26-18-5, as last amended by Laws of Utah 2019, Chapter 393

26-18-8, as last amended by Laws of Utah 2003, Chapter 90

26-18-103, as last amended by Laws of Utah 2013, Chapter 167

26-18-408, as last amended by Laws of Utah 2019, Chapter 393

26-18-411, as last amended by Laws of Utah 2019, Chapter 393

26-18-413, as last amended by Laws of Utah 2019, Chapters 60 and 393

26-36b-204, as last amended by Laws of Utah 2018, Chapters 384 and 468

26-36b-205, as last amended by Laws of Utah 2018, Chapters 384 and 468

26-36c-204, as last amended by Laws of Utah 2019, Chapter 1

26-40-106, as last amended by Laws of Utah 2019, Chapter 393

62A-2-120, as last amended by Laws of Utah 2019, Chapter 335

62A-15-629, as last amended by Laws of Utah 2018, Chapter 322

REPEALS:

26-18-404, as last amended by Laws of Utah 2019, Chapter 393

26-40-116, as last amended by Laws of Utah 2019, Chapter 393

Utah Code Sections Affected by Coordination Clause:

62A-2-120, as last amended by Laws of Utah 2019, Chapter 335

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

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

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

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

(a) establish, on a statewide basis, a program to safeguard against unnecessary or

inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;

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

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

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

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

(b) preadmission certification of nonemergency admissions;

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

(d) second surgical opinions;

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

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

(g) coordination of benefits; and

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

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

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

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

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

26-18-2.6. Dental benefits.

(1) (a) Except as provided in Subsection (8), the division [~~shall~~] may establish a

competitive bid process to bid out Medicaid dental benefits under this chapter.

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

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

(a) ability to manage dental expenses;

(b) proven ability to handle dental insurance;

(c) efficiency of claim paying procedures;

(d) provider contracting, discounts, and adequacy of network; and

(e) other criteria established by the department.

(3) The division shall request bids for the program's benefits[~~:~~] at least once every five years.

[~~(a) in 2011; and~~]

[~~(b) at least once every five years thereafter.~~]

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

(5) The division may not award contracts to:

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

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

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

(i) there are no responsive bidders; or

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

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

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

(8) (a) The division may:

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

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

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

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

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

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

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

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

26-18-3.1. Medicaid expansion.

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

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

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

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

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

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

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

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

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

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

(4) The Medicaid program shall provide for eligibility for persons as required by Subsection 26-18-3.9(2).

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

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

26-18-3.8. 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 the Patient Protection and Affordable Care Act, Public Law 111-148;

(ii) give priority to, but not be limited to, expanding the state's Utah Premium Partnership for Health Insurance 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.

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

(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 fiscal year 2021-22, 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 fiscal year 2021-22, and in each subsequent 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 5. Section **26-18-3.9** is amended to read:

26-18-3.9. Expanding the Medicaid program.

(1) As used in this section:

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

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

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

(d) "Medicaid Expansion Fund" means the Medicaid Expansion Fund created in Section 26-36b-208.

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

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

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

(3) The department shall expand the Medicaid program in accordance with this

Subsection (3) if the department:

(a) receives approval from CMS to:

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

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

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

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

(i) the Medicaid Expansion Fund;

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

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

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

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

(i) receives approval from CMS to:

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

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

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

(ii) pays the state portion of costs for the Medicaid expansion under this Subsection (4)

with funds from:

(A) the Medicaid Expansion Fund;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) July 1, 2020.

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

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

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

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

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

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

(i) the Medicaid Expansion Fund;

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

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

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

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

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

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

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

(i) the governor shall direct the Department of Health, Department of Human Services, and Department of Workforce Services to reduce commitments and expenditures by an amount sufficient to offset the deficiency:

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

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

(ii) the Division of Finance shall reduce allotments to the Department of Health, Department of Human Services, and Department of Workforce Services by a percentage:

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

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

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

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

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

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

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

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

(c) estimated costs to the state for the Medicaid expansion for the current and following fiscal years; [~~and~~]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The board shall:

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

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

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

(a) therapeutic appropriateness;

(b) overutilization or underutilization;

(c) therapeutic duplication;

(d) drug-disease contraindications;

(e) drug-drug interactions;

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

(g) clinical abuse and misuse;

(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order

to improve the quality of care;

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

(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;

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

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

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

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

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

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

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

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

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

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

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

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

[~~(h) an assessment of the impact of educational programs or interventions on~~

~~prescribing or dispensing practices; and~~]

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

(11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec. 712;

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

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

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

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

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

(c) therapeutic appropriateness;

(d) overutilization or underutilization;

(e) appropriate use of generics;

(f) therapeutic duplication;

(g) drug-disease contraindications;

(h) drug-drug interactions;

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

(j) drug allergy interactions; and

(k) clinical abuse and misuse;

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

(a) the name and description of the medication;

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

(c) special directions and precautions for use;

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

(e) techniques for self-monitoring drug therapy;

(f) proper storage;

(g) prescription refill information; and

(h) action to be taken in the event of a missed dose; and

(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:

(a) the name, address, age, and gender of the recipient;

(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;

(c) the pharmacist's comments on the individual's drug therapy;

(d) name of prescriber; and

(e) name of drug, dose, duration of therapy, and directions for use.

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

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

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

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

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

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

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

(A) means use of the emergency department to receive health care that is [~~nonemergent~~] non-emergent as defined by the department by administrative rule adopted in

accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and the Emergency Medical Treatment and Active Labor Act; and

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

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

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

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

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

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

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

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

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

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

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

[~~accountable~~] managed care plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(d) before July 1, 2015, convene representatives from the accountable care organizations, pre-paid mental health plans, an organization representing hospitals, an~~

~~organization representing physicians, and a county mental health and substance abuse authority to discuss alternatives to emergency department care, including:~~]

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

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

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

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

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

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

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

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

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

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

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

(1) For purposes of this section:

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

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

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

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

(c) "Federal poverty level" means the poverty guidelines established by the Secretary of

the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).

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

(e) "Homeless":

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

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

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

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

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

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

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

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

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

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

(i) through the traditional fee for service Medicaid model in counties without Medicaid

accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented;

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

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

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

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

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

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

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

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

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

implement the enhancement waiver program; and

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

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

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

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

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

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

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

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

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

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

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

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

(A) qualifies for the health coverage improvement program described in Section

26-18-411; and

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

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

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

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

(i) by contracting with an entity that:

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

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

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

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

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

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

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

[~~(g) During each general session of the Legislature, the department shall report to the Social Services Appropriations Subcommittee whether the University of Utah School of~~

~~Dentistry will have sufficient funds to make the transfer required by Subsection (2)(f) for the current fiscal year.~~]

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

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

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

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

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

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

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

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

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

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

[~~(4)~~] (3) (a) If the waivers requested under Subsection (1)(a) are granted, the Medicaid program shall begin providing dental services in the manner described in Subsection (2) no later than July 1, 2017.

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

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

[~~(5)~~] (4) If the federal share of the cost of providing dental services under this section will be less than 65% during any portion of the next fiscal year, the Medicaid program shall cease providing dental services under this section no later than the end of the current fiscal year.

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

26-36b-204. Hospital financing of health coverage improvement program Medicaid waiver expansion -- Hospital share.

(1) The hospital share is:

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) A Medicaid accountable care organization shall, on or before October 15 of each

year, report to the department the following data from the prior state fiscal year for each private hospital, state teaching hospital, and non-state government hospital provider that the Medicaid accountable care organization contracts with:

(a) for the traditional Medicaid population:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments; and

(b) if the Medicaid accountable care organization enrolls any individuals in the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion, for the population newly eligible for any of those programs:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

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

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

26-36b-205. Calculation of assessment.

(1) (a) Except as provided in Subsection (1)(b), an annual assessment is payable on a quarterly basis for each private hospital 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 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, described in [~~Subsection 26-36b-204(1)~~] Subsections 26-36b-204(1) and 26-36b-204(3), 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, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this chapter.

(e) Any quarterly changes to the uniform assessment rate shall be applied 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 2017, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2013, and June 30, 2014; 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 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) 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.

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

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

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

26-36c-204. Hospital financing.

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

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

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

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

26-40-106. Program benefits.

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

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

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

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

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

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

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

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

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

(1) As used in this section:

(a) (i) "Applicant" means:

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

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

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

(D) a department contractor;

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

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

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

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

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

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

(e) "Personal identifying information" means:

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

(ii) date of birth;

(iii) physical address and email address;

(iv) telephone number;

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

(vi) social security number;

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

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

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

(i) personal identifying information;

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

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

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

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

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

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

(D) retention of personal identifying information, including fingerprints, for monitoring and notification as described in Subsections (3)(d) and (4).

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

(3) The office:

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

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

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

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

(ii) submit the applicant's personal identifying information and fingerprints to the bureau for a criminal history search of applicable national criminal background databases;

(iii) search the Department of Human Services, Division of Child and Family Services' Licensing Information System described in Section 62A-4a-1006;

(iv) search the Department of Human Services, Division of Aging and Adult Services' vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1;

(v) search the juvenile court records for substantiated findings of severe child abuse or neglect described in Section 78A-6-323; and

(vi) search the juvenile court arrest, adjudication, and disposition records, as provided under Section 78A-6-209;

(b) shall conduct a background check of an applicant for an initial background check upon submission of the information described under Subsection (2)(a);

(c) may conduct all or portions of a background check of an applicant, as provided by rule, made by the office in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(i) for an annual renewal; or

(ii) when the office determines that reasonable cause exists;

(d) may submit an applicant's personal identifying information, including fingerprints, to the bureau for checking, retaining, and monitoring of state and national criminal background databases and for notifying the office of new criminal activity associated with the applicant;

(e) shall track the status of an approved applicant under this section to ensure that an approved applicant is not required to duplicate the submission of the applicant's fingerprints if the applicant applies for:

(i) more than one license;

(ii) direct access to a child or a vulnerable adult in more than one human services program; or

(iii) direct access to a child or a vulnerable adult under a contract with the department;

(f) shall track the status of each license and each individual with direct access to a child

or a vulnerable adult and notify the bureau [~~when the license has expired~~] within 90 days after the day on which the license expires or the individual's direct access to a child or a vulnerable adult [~~has ceased~~] ceases;

(g) shall adopt measures to strictly limit access to personal identifying information solely to the [~~office employees~~] individuals responsible for processing and entering the applications for background checks and to protect the security of the personal identifying information the office reviews under this Subsection (3);

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

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

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

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

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

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

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

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

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

(d) The bureau is authorized to submit the fingerprints to the Federal Bureau of

Investigation Next Generation Identification System, to be retained in the Federal Bureau of Investigation Next Generation Identification System for the purpose of:

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

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

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

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

(i) discard and destroy any retained fingerprints; and

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

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

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

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

(iii) prostitution;

(iv) an offense included in:

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

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

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

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

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

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

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

(ix) [~~a conviction for~~] a felony or misdemeanor offense committed outside of the state that, if committed in the state, would constitute a violation of an offense described in Subsections (5)(a)(i) through (viii).

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

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

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

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

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

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

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

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

(vi) has a listing in the Department of Human Services, Division of Aging and Adult

Services' vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1;

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

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

(A) under 28 years of age; or

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

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

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

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

(i) the date of the offense or incident;

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

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

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

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

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

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

(B) sexual abuse;

(C) sexual exploitation; or

(D) negligent treatment;

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

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

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

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

(d) At the conclusion of the comprehensive review described in Subsection (6)(a), the office may not deny an application to an applicant solely because the applicant was convicted of an offense that occurred 10 or more years before the day on which the applicant submitted the information required under Subsection (2)(a) if:

(i) the applicant has not committed another misdemeanor or felony offense after the day on which the conviction occurred; and

(ii) the applicant has never been convicted of an offense described in Subsection (14)(c).

[~~(d)~~] (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the office may make rules, consistent with this chapter, to establish procedures for the comprehensive review described in this Subsection (6).

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

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

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

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

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

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

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

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

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

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

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

(ii) the individual's application is conditionally approved by the office under Subsection (8); or

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

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

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

(b) (i) the individual is associated with the licensee or department contractor;

(ii) the individual has a current background screening approval issued by the office under this section;

(iii) one of the following circumstances, that the office has not yet reviewed under Subsection (6), applies to the individual:

(A) the individual was charged with an offense described in Subsection (5)(a);

(B) the individual is listed in the Licensing Information System, described in Section 62A-4a-1006;

(C) the individual is listed in the vulnerable adult abuse, neglect, or exploitation database, described in Section 62A-3-311.1;

(D) the individual has a record in the juvenile court of a substantiated finding of severe child abuse or neglect, described in Section 78A-6-323; or

(E) the individual has a record of an adjudication in juvenile court for an act that, if committed by an adult, would be a felony or a misdemeanor as described in Subsection (5)(a) or (6); and

(iv) the individual is directly supervised by an individual who:

(A) has a current background screening approval issued by the office under this section; and

(B) is associated with the licensee or department contractor;

(c) the individual:

(i) is not associated with the licensee or department contractor; and

(ii) is directly supervised by an individual who:

(A) has a current background screening approval issued by the office under this section; and

(B) is associated with the licensee or department contractor;

(d) the individual is the parent or guardian of the child, or the guardian of the vulnerable adult;

(e) the individual is approved by the parent or guardian of the child, or the guardian of the vulnerable adult, to have direct access to the child or the vulnerable adult;

(f) the individual is only permitted to have direct access to a vulnerable adult who voluntarily invites the individual to visit; or

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

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

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

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

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

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

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

(c) If the notice under Subsection (12)(a) states that the applicant's application is denied, the notice shall further advise the applicant that the applicant may, under Subsection

62A-2-111(2), request a hearing in the department's Office of Administrative Hearings, to challenge the office's decision.

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

(i) defining procedures for the challenge of [~~its~~] the office's background check decision described in Subsection (12)(c); and

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

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

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

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

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

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

(i) federal law or rule permits otherwise; or

(ii) the requirements would prohibit the Division of Child and Family Services or a

court from placing a child with:

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

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

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

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

(A) child abuse, as described in Section 76-5-109;

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

(C) abuse or neglect of a child with a disability, as described in Section 76-5-110;

(D) endangerment of a child or vulnerable adult, as described in Section 76-5-112.5;

(E) aggravated murder, as described in Section 76-5-202;

(F) murder, as described in Section 76-5-203;

(G) manslaughter, as described in Section 76-5-205;

(H) child abuse homicide, as described in Section 76-5-208;

(I) homicide by assault, as described in Section 76-5-209;

(J) kidnapping, as described in Section 76-5-301;

(K) child kidnapping, as described in Section 76-5-301.1;

(L) aggravated kidnapping, as described in Section 76-5-302;

(M) human trafficking of a child, as described in Section 76-5-308.5;

(N) an offense described in Title 76, Chapter 5, Part 4, Sexual Offenses;

(O) sexual exploitation of a minor, as described in Section 76-5b-201;

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

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

(R) aggravated robbery, as described in Section 76-6-302; or

(S) domestic violence, as described in Section 77-36-1; or

(ii) an offense committed outside the state that, if committed in the state, would constitute a violation of an offense described in Subsection (14)(c)(i).

(d) Notwithstanding Subsections (5) through (9), the office shall deny a license or license renewal to a prospective foster parent or a prospective adoptive parent if, within the five years immediately preceding the day on which the individual's application or license would otherwise be approved, the applicant was convicted of a felony involving conduct that constitutes a violation of any of the following:

(i) aggravated assault, as described in Section 76-5-103;

(ii) aggravated assault by a prisoner, as described in Section 76-5-103.5;

(iii) mayhem, as described in Section 76-5-105;

(iv) an offense described in Title 58, Chapter 37, Utah Controlled Substances Act;

(v) an offense described in Title 58, Chapter 37a, Utah Drug Paraphernalia Act;

(vi) an offense described in Title 58, Chapter 37b, Imitation Controlled Substances Act;

(vii) an offense described in Title 58, Chapter 37c, Utah Controlled Substance Precursor Act; or

(viii) an offense described in Title 58, Chapter 37d, Clandestine Drug Lab Act.

(e) In addition to the circumstances described in Subsection (6)(a), the office shall conduct the comprehensive review of an applicant's background check pursuant to this section if the registry check described in Subsection (14)(a) indicates that the individual is listed in a child abuse and neglect registry of another state as having a substantiated or supported finding of a severe type of child abuse or neglect as defined in Section 62A-4a-1002.

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

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

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

(a) a written application that:

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

(ii) includes a certification by a licensed physician or designated examiner stating that the physician or designated examiner has examined the adult within a three-day period

immediately preceding that certification, and that the physician or designated examiner is of the opinion that, due to mental illness, the adult poses a substantial danger to self or others; or

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

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

(A) the adult has a mental illness; and

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

(ii) completing a temporary commitment application that:

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

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

(C) states the specific nature of the danger;

(D) provides a summary of the observations upon which the statement of danger is based; and

(E) provides a statement of the facts that called the adult to the peace officer's or mental health officer's attention.

(2) If at any time a patient committed under this section no longer meets the commitment criteria described in Subsection (1), the local mental health authority or the local mental health authority's designee shall document the change and release the patient.

(3) A patient committed under this section may be held for a maximum of 24 hours after commitment, excluding Saturdays, Sundays, and legal holidays, unless:

(a) as described in Section 62A-15-631, an application for involuntary commitment is commenced, which may be accompanied by an order of detention described in Subsection 62A-15-631(4); or

(b) the patient makes a voluntary application for admission.

(4) Upon a written application described in Subsection (1)(a) or the observation and belief described in Subsection (1)(b)(i), the adult shall be:

(a) taken into a peace officer's protective custody, by reasonable means, if necessary for public safety; and

(b) transported for temporary commitment to a facility designated by the local mental

health authority, by means of:

(i) an ambulance, if the adult meets any of the criteria described in Section 26-8a-305;

(ii) an ambulance, if a peace officer is not necessary for public safety, and transportation arrangements are made by a physician, designated examiner, or mental health officer;

(iii) the city, town, or municipal law enforcement authority with jurisdiction over the location where the individual to be committed is present, if the individual is not transported by ambulance; [~~or~~]

(iv) the county sheriff, if the designated facility is outside of the jurisdiction of the law enforcement authority described in Subsection (4)(b)(iii) and the individual is not transported by ambulance[~~.~~]; or

(v) nonemergency secured behavioral health transport as that term is defined in Section 26-8a-102.

(5) Notwithstanding Subsection (4):

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

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

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

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

Section 18. **Repealer.**

This bill repeals:

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

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

Section 19. **Coordinating H.B. 436 with H.B. 137 -- Superseding technical and substantive amendments.**

If this H.B. 436 and H.B. 137, Child Placement Background Check Limits, both pass and become law, it is the intent of the Legislature that the amendments to Section 62A-2-120 in this H.B. 436 supersede the amendments to Section 62A-2-120 in H.B. 137 when the Office of Legislative Research and General Counsel prepares the Utah Code database for publication.