DMHF Rules Matrix 8-17-23

Rule Summary	Bulletin Publication	Effective
R414-502 Nursing Facility Levels of Care; The purpose of this change is to update and clarify the rule text as needed. This amendment, therefore, recodifies authorizing citations to coincide with the merger of the Department of Health and Human Services. It further updates names, terms, and entities and makes other technical and structural changes.	**8-1-23**	**9-7-23**
R414-9 Federally Qualified Health Centers and Rural Health Clinics (Five-Year Review); The Department will continue this rule because it implements payment methodologies for federally qualified health centers and rural health clinics.	**8-15-23**	**7-19-23**

The public may access proposed rules published in the State Bulletin at https://rules.utah.gov/publications/utah-state-bull/

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF PROPOSED RULE		
TYPE OF FILING: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-502**	**Filing ID: 55498**

Agency Information

1. Department:	Health and Human Services	
Agency:	Health Care Financing, Coverage and Reimbursement Policy	
Building:	Cannon Health Building	
Street address:	288 N. 1460 W.	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Jonah Shaw	385-310-2389	jshaw@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:

R414-502. Nursing Facility Levels of Care.

3. Purpose of the new rule or reason for the change:

The purpose of this change is to update and clarify the rule text as needed. Additionally, this rule updates the authorizing citations following the 2023 Legislative Session recodification of the Department of Health and Human Services' statute.

4. Summary of the new rule or change:

This amendment updates names, terms, and entities in the text. It also makes other technical and structural changes. Additionally, this amendment updates the authorizing citations of this rule, this is due to the recodification and consolidation of the Department of Health and Human Services' statute.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no impact to the state budget as there are only minor changes and technical updates.

B) Local governments:

There is no impact on local governments as they neither fund nor provide benefits under the Medicaid program.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no impact on small businesses as there are only minor changes and technical updates.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no impact on non-small businesses as there are only minor changes and technical updates.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no impact to other persons or entities as there are only minor changes and technical updates.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs to a single person or entity as there are only minor changes and technical updates.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Executive Director of the Department of Health and Human Services, Tracy Gruber, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 26B-1-213	Section 26B-3-108	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)

A) Comments will be accepted until:	08/31/2023

9. This rule change MAY become effective on:	09/07/2023

NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	06/15/2023

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-502. Nursing Facility Levels of Care.
R414-502-1. [~~Introduction~~]Purpose and Authority.

(1) This rule defines the levels of care provided in nursing facilities.

(2) Sections 26B-1-213 and 26B-3-108 authorize this rule.

R414-502-2. Definitions.

The definitions in Section R414-1-2 and Section R414-501-2 apply to this rule.

R414-502-3. Approval of Level of Care.

(1) The Department shall document that at least two of the following factors exist when it determines whether an applicant has mental or physical conditions that require the level of care provided in a nursing facility or equivalent care provided through a Medicaid [~~H~~]home and [~~C~~]community-[~~B~~]based [~~W~~]waiver program:

(a) due to diagnosed medical conditions, the applicant requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up;

(b) the attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care[~~;~~], or equivalent care provided through a Medicaid [~~H~~]home and [~~C~~]community-[~~B~~]based [~~W~~]waiver program~~-~~; or

(c) the medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid [~~H~~]home and [~~C~~]community-[~~B~~]based [~~W~~]waiver program.

(2) The Department shall determine whether at least two of the factors described in Subsection [~~R414-502-3~~](1) exist by reviewing the following clinical documentation:

(a) a current history and physical examination completed by a physician;

(b) a comprehensive resident assessment completed, coordinated, and certified by a registered nurse;

(c) a social services evaluation that meets the criteria in 42 CFR 456.370 and completed by a person licensed as a social worker, or higher degree of training and licensure;

(d) a written plan of care established by a physician;

(e) a physician's written certification that the applicant requires nursing facility placement; and

(f) documentation [~~which indicates~~]indicating that [~~all~~]less restrictive alternatives or services to prevent or defer nursing facility care have been explored.

(3) If the Department finds that at least two of the factors described in Subsection [~~R414-502-3~~](1) exist, the Department shall determine whether the applicant meets nursing facility level of care and is medically-approved for Medicaid reimbursement of nursing facility services or equivalent care provided through a Medicaid [~~H~~]home and [~~C~~]community-[~~B~~]based [~~W~~]waiver program. Meeting medical eligibility for nursing facility services does not guarantee Medicaid payment. Financial eligibility and other [~~H~~]home and [~~C~~]community-[~~B~~]based [~~W~~]waiver targeting criteria [~~shall~~]apply.

(4) During the Coronavirus (COVID-19) public health emergency period, an individual [~~shall~~]may temporarily meet nursing facility level of care for a period of illness, [~~when~~]if the individual:

(a) is COVID-19 positive;

(b) is experiencing active COVID-19 symptoms; or

(c) is admitting directly from:

(i) a licensed, assisted living facility;

(ii) a licensed intermediate care facility for people with intellectual disabilities; or

(iii) an acute care, inpatient hospital.

R414-502-4. Approval of Differential Levels of Care.

The Department shall pay nursing facilities a rate differential for residents who meet nursing facility level of care and any of the criteria listed in Sections R414-502-5 through R414-502-7.

R414-502-5. Criteria for Intensive~~-~~ Skilled Care.

A nursing facility must demonstrate that the applicant meets the following criteria before the Department may authorize Medicaid reimbursement for intensive~~-~~ skilled care[~~:~~].

(1) The applicant meets the need for skilled services provided by a nursing facility certified pursuant to 42 CFR 409.20 through 409.35, or a swing bed hospital approved by the Centers for Medicare and Medicaid Services to furnish skilled nursing facility care in the Medicare program.

(2) The following routine~~-~~ skilled care does not qualify as intensive~~-~~ skilled care in making a determination under [~~Section R414-502-5~~]this section:

(a) [~~S~~]skilled nursing services described in 42 CFR 409.33(b);

(b) [~~S~~]skilled rehabilitation services described in 42 CFR 409.33(c);

(c) [~~R~~]routine monitoring of medical gases after a therapy regimen;

(d) [~~R~~]routine enteral tube and gastronomy feedings; and

(e) [~~R~~]routine isolation room and techniques.

(3) The applicant has exhausted Medicare benefits or has been denied by Medicare for other reasons other than level of care requirements.

(4) The applicant requires and receives at least five additional hours of direct, licensed professional nursing care daily, including a combination of specialized care and services, and assessment by a registered nurse and 24-hour observation.

(5) The applicant meets criteria for intensive~~-~~ skilled care if the attending physician makes any one of the following determinations:

(a) [~~T~~]there is no reasonable expectation that the applicant will benefit further from any care and services available in an acute care hospital that are not available in a nursing facility[~~;~~], or[

~~(b)~~] [~~T~~]the applicant's condition requires physician follow-up at the nursing facility at least once every 30 days;

([~~e~~]b) [~~A~~]an interdisciplinary team may indicate a therapeutic leave of absence from the nursing facility is appropriate either to facilitate discharge planning or to enhance the applicant's medical, social, educational, and habilitation potential; and

([~~d~~]c) [~~E~~]except in extraordinary circumstances, the applicant has been hospitalized immediately before admission to the nursing facility.

(6) The applicant has continuously required skilled care, either through Medicare or Medicaid, since admission to the nursing facility.

(7) [~~If t~~]The attending physician has written and signed progress notes at the time of each physician visit that reflect the current medical condition of the applicant.

(8) An applicant who was previously approved for intensive~~-~~ skilled care and later downgraded to a lower care level may return to intensive~~-~~ skilled care instead of being hospitalized in an acute care setting if~~-~~:

(a) [~~A~~]a complication occurs that involves the condition for which the applicant was originally approved for intensive~~-~~ skilled care; and

(b) [~~I~~]it has been less than 30 days since the termination of the previous intensive~~-~~ skilled care.

R414-502-6. Criteria for Behaviorally Complex Program.

[~~In order f~~]For the Department to authorize Medicaid coverage for the Behaviorally Complex Program, a nursing facility must:

(1) [~~D~~]demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff as documented by one or more of the following behaviors:

(a) [~~T~~]the resident engages in wandering behavior with no rational purpose, is oblivious to [~~his~~]self needs or safety, and places [~~his~~]self and others at significant risk of physical illness or injury;

(b) [~~T~~]the resident engages in verbally abusive behavior where [~~he~~]the resident threatens, screams, or curses at others;

(c) [~~T~~]the resident presents a threat of hitting, shoving, scratching, or sexually abusing other residents[~~.~~]; or

(d) [~~T~~]the resident engages in socially inappropriate and disruptive behavior by doing of one of the following:

(i) [~~M~~]makes disruptive sounds, noises, and screams;

(ii) [~~E~~]engages in self-abusive acts;

(iii) engages in [~~I~~]inappropriate sexual behavior;

(iv) [~~D~~]disrobes in public;

(v) [~~S~~]smears or throws food or feces;

(vi) [~~H~~]hoards; and

(vii) rummages through others belongings.

(e) [~~T~~]the resident refuses assistance with medication administration or activities of daily living; or

(f) [~~T~~]the resident's behavior interferes significantly with the stability of the living environment and interferes with other residents' ability to participate in activities or engage in social interactions[~~.~~]; and

(2) [~~D~~]demonstrate that an appropriate behavioral intervention program has been developed for the resident as follows:[~~.~~]

(a) [~~All~~]behavior intervention programs shall:

(b) [~~Be a precisely~~]plan[~~ned~~] the systematic application of [~~the~~]methods and experimental findings of behavioral science with the intent to reduce observable negative behaviors;

(c) [~~I~~]incorporate processes and methodologies that are the least restrictive alternatives available for producing the desired outcomes;

(d) [~~B~~]be conducted following [~~only~~]identification and, if feasible, remediation of environmental and social factors that likely precipitate or reinforce the inappropriate behavior;

(e) [~~I~~]incorporate a process for identifying and reinforcing a desirable replacement behavior;

(f) [~~I~~]include a program data sheet; and

(g) [~~I~~]include a behavior baseline profile that consists of [~~all of~~]the following:

(i) [~~A~~]include the applicant name;

(ii) [~~D~~]include the date, time, location, and specific description of the undesirable behavior;

(iii) [~~P~~]include persons and conditions present before and at the time of the undesirable behavior;

(iv) demonstrate [~~I~~]interventions for the undesirable behavior and their results; and

(v) provide [~~R~~]recommendations for future action[~~.~~]; and

(h) [~~T~~]the interdisciplinary team shall include a behavior intervention plan that consists of [~~all of~~]the following:

(i) [~~T~~]the applicant's name, the date the plan is prepared, and when the plan will be used;

(ii) [~~T~~]the objectives stated in terms of specific behaviors;

(iii) [~~T~~]the names, titles, and signatures of persons responsible for conducting the plan; and

(iv) [~~T~~]the methods and frequency of data collection and review.

R414-502-7. Criteria for Specialized Rehabilitative Services for Residents with Intellectual Disabilities.

A nursing facility must demonstrate that the applicant meets the following criteria before the Department may authorize Medicaid coverage for an applicant for specialized rehabilitative services:

(1) [~~T~~]the nursing facility must arrange for specialized rehabilitative services for [~~clients~~]members with intellectual disabilities who are residing in nursing homes;

(2) [~~T~~]the individual must meet the criteria for Nursing Facility III Level of Care, [~~(~~]excluding residents who receive the intensive~~-~~skilled or behaviorally complex rate[~~)~~];

(3) [~~T~~]the individual must have a Preadmission Screening and Resident Review (PASRR) Level II Evaluation that indicates the resident needs specialized rehabilitation. The nursing facility must assure that needed services are provided by qualified personnel under the written order of a physician[~~ by qualified personnel~~]; and

(4) [~~T~~]the nursing facility must document the need for specialized rehabilitative services in the resident's comprehensive plan of care.

(5) Specialized rehabilitative services may include[~~ but are not limited to~~]:

(a) [~~M~~]medication management and monitoring effectiveness and side effects of medications prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;

(b) [~~T~~]the provision of a structured environment to include structured socialization activities to diminish tendencies toward isolation and withdrawal;

(c) [~~D~~]development, maintenance, and implementation of programs designed to teach individuals daily living skills that may include[~~ but are not limited to~~]:

(i) [~~G~~]grooming and personal hygiene;

(ii) [~~M~~]mobility;

(iii) [~~N~~]nutrition, health, and self-feeding;

(iv) [~~M~~]medication management;

(v) [~~M~~]mental health education;

(vi) [~~M~~]money management;

(vii) [~~M~~]maintenance of the living environment;[~~ and~~]

(viii) [~~O~~]occupational, speech, and physical therapy obtained from providers outside the nursing facility who specialize in providing services for persons with intellectual disabilities at the intensity level necessary to attain the desired goals of independence and self-determination[~~.~~];

(d) [~~F~~]formal behavior modification programs; and

(e) [~~D~~]development of appropriate~~-~~person support networks.

R414-502-8. Criteria for Intermediate Care Facility for Persons with Intellectual Disability.

An intermediate care facility for persons with intellectual disabilities (ICF/ID) must demonstrate that the applicant meets the following criteria before the Department may authorize Medicaid coverage for an individual who resides in an ICF/ID.

(1) The individual must have a diagnosis of:

(a) [~~A~~]an intellectual disability in accordance with 42 CFR 483.102(b)(3); or

(b) [~~A~~]a condition closely related to intellectual disability in accordance with 42 CFR 435.1010.

(2) For individuals seven years of age and older, the presence of a diagnosis alone is not sufficient to qualify for admission to an intermediate care facility for persons with intellectual disabilities. The diagnosis identified in Subsection [~~R414-502-8~~](1) must result in documented substantial functional limitations in three or more of the following seven areas of major life activity that include:

(a) [~~S~~]self-care[~~:~~], wherein the individual requires assistance, training, and supervision to eat, dress, groom, bathe, or use the toilet;

[~~(i) The individual requires assistance, training and supervision to eat, dress, groom, bathe, or use the toilet.~~]

(b) the use of [~~R~~]receptive and expressive language, wherein the individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests, or cannot follow two-step instructions;

[~~(i) The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests, or cannot follow two-step instructions.~~]

(c) difficulty [~~L~~]learning, wherein the individual has a valid diagnosis of an intellectual disability based on criteria found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994;

[~~(i) The individual has a valid diagnosis of an intellectual disability based on criteria found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, 1994.~~]

(d) lack of [~~M~~]mobility, wherein the individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without an assistive device;

[~~(i) The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without an assistive device.~~]

(e) lack of [~~S~~]self-direction, the individual is a danger to self or others without supervision, and wherein the individual is seven through 17 years of age and significantly at risk in making age-appropriate decisions, or, in the case of an adult, the individual cannot provide informed consent for medical care, personal safety, or for legal, financial, rehabilitative, and residential issues, and has been declared legally incompetent;

[~~(i) The individual is seven through 17 years of age and significantly at risk in making age appropriate decisions. Or, in the case of an adult, cannot provide informed consent for medical care, personal safety, or for legal, financial, rehabilitative, and residential issues, and has been declared legally incompetent. The individual is a danger to himself or others without supervision.~~]

(f) lack of [~~The~~]capacity for independent living, wherein the individual who is seven through 17 years of age cannot locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food or money from strangers, or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills; or

[~~(i) The individual who is seven through 17 years of age cannot locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food or money from strangers, or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.~~]

(g) lack of [~~E~~]economic self-sufficiency, wherein the individual receives disability benefits, cannot work more than 20 hours a week, or is paid less than minimum wage without employment support. This does not apply to children under 18 years of age[~~(not applicable to children under 18 years of age);~~].

[~~(i) The individual receives disability benefits, cannot work more than 20 hours a week, or is paid less than minimum wage without employment support.~~]

(3) The Department considers a child under [~~the age of~~]seven years of age to be at risk for functional limitation in three or more areas of major life activity. The child may satisfy [~~this~~]the criteria for functional limitations if the child has been diagnosed with an intellectual disability or a condition closely related to intellectual disability. The Department does not require separate documentation of the limitations defined in Subsection [~~R414-502-8~~](2) until the child turns seven years of age.

(4) To meet the criteria of a condition closely related to an intellectual disability, an individual must manifest the condition before the individual turns 22 years of age and the condition must be likely to continue. [~~A diagnosis may qualify as a condition closely related to an intellectual disability only if the child meets the criteria defined in 42 CFR 435.1010. ~~]The following criteria further specify the Department's consideration of a closely related condition[~~ is a list of diagnoses the Department considers to be conditions closely related to an intellectual disability:~~].

(a) [~~Cerebral palsy. ~~]The Department does not require [~~individuals~~]an individual to demonstrate an intellectual impairment [~~for this diagnosis~~]of cerebral palsy, but [~~they ~~]the individual must demonstrate [~~they have ~~]functional limitations as described in Subsection [~~R414-502-8~~](2)[~~:~~].

(b) [~~Epilepsy. ~~]The Department does not require [~~individuals~~]an individual to demonstrate an intellectual impairment [~~for this diagnosis~~]of epilepsy, but [~~they ~~]the individual must demonstrate [~~they have ~~]functional limitations as described in Subsection [~~R414-502-8~~](2)[~~:~~].

[~~(c) [Autism Spectrum Disorder. The Department requires an individual to meet the following criteria under this category:~~

~~(i) Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifests by all three of the following:~~

~~(A) Deficits in social-emotional reciprocity, ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction;~~

~~(B) Deficits in non-verbal communicative behaviors used for social interaction, ranging from poorly integrated verbal and non-verbal communication through abnormalities in eye contact and body language, or deficits in understanding and use of non-verbal communication to total lack of facial expression or gestures;~~

~~(C) Deficits in developing and maintaining relationships appropriate to developmental level (beyond those with caregivers), ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play, and in making friends, to an apparent absence of interest in people.~~

~~(ii) Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:~~

~~(A) Stereotyped or repetitive speech, motor movements, or use of objects (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases);~~

~~(B) Excessive adherence to routines, ritualized patterns of verbal or non-verbal behavior, or excessive resistance to change (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes);~~

~~(C) Highly restricted, fixated interests with abnormal intensity or focus, (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests);~~

~~(D) Hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment (such as apparent indifference to pain, heat and cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).~~]

(5)(a) The Department requires an individual to meet the following criteria under the category of autism spectrum disorder:

(i) persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifested by the following:

(A) deficits in social-emotional reciprocity, ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction;

(B) deficits in non-verbal communicative behaviors used for social interaction, ranging from poorly integrated verbal and non-verbal communication through abnormalities in eye contact and body language, or deficits in understanding and use of non-verbal communication to total lack of facial expression or gestures; and

(C) deficits in developing and maintaining relationships appropriate to developmental level, ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends, to an apparent absence of interest in people; and

(ii) restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:

(A) stereotyped or repetitive speech, motor movements, or use of objects;

(B) excessive adherence to routines, ritualized patterns of verbal or non-verbal behavior, or excessive resistance to change;

(C) highly restricted, fixated interests with abnormal intensity or focus, such as strong attachment to or preoccupation with unusual objects and excessively circumscribed or perseverative interests; or

(D) hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment, such as apparent indifference to pain, heat and cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects.

([~~iii~~]b) Symptoms must be present in early childhood.[~~(but may not become fully manifest until social demands exceed limited capacities).~~]

([~~iv~~]c) Symptoms must together limit and impair everyday functioning.

([~~d~~]d) An individual must have a [~~S~~]severe brain injury[~~. May be~~] that is the result of an acquired brain injury, traumatic brain injury, stroke, anoxia, or meningitis[~~;~~].

([~~e~~]e) An individual must have a diagnosis of [~~F~~]fetal alcohol syndrome[~~;~~].

([~~f~~]f) An individual must have [~~C~~]chromosomal disorders such as Down syndrome, fragile x syndrome, and Prader-Willi syndrome[~~;~~].

([~~g~~]g) Individuals with [~~O~~]other genetic disorders[~~. Examples~~] that include Williams syndrome, spina bifida, and phenylketonuria may qualify.

([~~5~~]6) The following conditions do not qualify as conditions closely related to intellectual disabilities. Nevertheless, the Department may consider a person with any of these conditions if there is a simultaneous occurrence of a qualifying condition as cited in Subsections [~~R414-502-8~~](1)(a) and (b):

(a) [~~L~~]learning disability;

(b) [~~B~~]behavior or conduct disorders;

(c) [~~S~~]substance abuse;

(d) [~~H~~]hearing [~~impairment~~]or vision impairment;

(e) [~~M~~]mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;

(f) [~~B~~]borderline intellectual functioning, a related condition that does not result in an intellectual impairment, developmental delay, or ["]at risk["] designations;

(g) [~~P~~]physical problems such as multiple sclerosis, muscular dystrophy, spinal cord injuries, and amputations;

(h) [~~M~~]medical health problems such as cancer, acquired immune deficiency syndrome, and terminal illnesses;

(i) [~~N~~]neurological problems not associated with intellectual deficits. Examples include Tourette's syndrome, fetal alcohol effects, and non-verbal learning disability; and

(j) [~~M~~]mild traumatic brain injury such as minimal brain injury and post-concussion syndrome.

([~~6~~]7) An individual who was admitted to an ICF/ID before August 27, 2009, is eligible for continued stay as long as the individual continues to meet the requirements in effect before that date. A resident who was admitted to an ICF/ID before August 27, 2009, is only required to meet the revised eligibility criteria [~~when~~]if there is a break in stay wherein the individual resides in a setting that is not a Medicaid-certified ICF/ID [~~nursing~~]facility or hospital.

([~~7~~]8) Before admission to an ICF/ID, the facility must provide each potential resident with a two-sided fact sheet known as a Community Supports Waiver and ICF/ID Fact Sheet or [~~(~~]Form IFS 10[~~) that~~], which offers information about ICFs/IDs and the Community Supports Waiver for People with Intellectual Disabilities and Other Related Conditions. Each resident's record must also contain a Freedom of Choice Acknowledgement Form or [~~an acknowledgement (~~]Form IFS 20[~~)~~], signed by the resident or legal representative, which verifies that the facility provided the Form IFS 10 before admission.

KEY: Medicaid
Date of Last Change: September 22, 2020
Notice of Continuation: May 31, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-[~~5~~]213; [~~26-18-3~~]26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-9**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Jonah Shaw	(385) 310-2389	jshaw@utah.gov

Please address questions regarding information on this notice to the persons listed above.

General Information

2. Rule catchline:

R414-9. Federally Qualified Health Centers and Rural Health Clinics.

3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:

Section 26B-3-108 requires the Department to implement the Medicaid program through administrative rules, and Section 26B-1-213 grants the Department the authority to adopt, amend, or rescind these rules.

4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:

The Department did not receive any written comments regarding this rule.

5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:

The Department will continue this rule because it implements payment methodologies for federally qualified health centers and rural health clinics.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	07/19/2023

Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-9. Federally Qualified Health Centers and Rural Health Clinics.
R414-9-1. Introduction and Authority.

(1) This rule establishes Medicaid payment methodologies for federally qualified health centers (FQHCs) and rural health clinics (RHCs).

(2) 42 CFR Subpart X, Section 26B-3-102, and Section 26B-3-104 authorize this rule.

R414-9-2. Definitions.

In addition to the definitions in Rule R414-1, the following definitions apply to this rule:

(1) "CLIA" means clinical laboratory improvement amendments.

(2) "Federally qualified health center" (FQHC) means a health center qualified under 42 CFR Subpart X.

(3) "HRSA" means health resources and services administration.
(4) "Rural health clinic" (RHC) means a health clinic qualified under 42 CFR Subpart X.
(5) "Scope of services change" (SSC) means having a change in services, intensity, amount, or duration of services.

R414-9-3. Payment Choices for FQHCs.

Payment choices for FQHCs must be in accordance with Pages 2, 2a, 2b, and 2c of Attachment 4.19-B of the Medicaid State Plan.

R414-9-4. Prospective Payment System (PPS).

Prospective payments to FQHCs must be in accordance with Pages 2b and 2c of Attachment 4.19-B of the Medicaid State Plan.

R414-9-5. Alternate Payment Method.

The alternate payment method for FQHCs must be in accordance with Pages 2b and 2c of Attachment 4.19-B of the Medicaid State Plan.

R414-9-6. Rural Health Clinics.

Payments to rural health clinics must be in accordance with Page 2c of Attachment 4.19-B of the Medicaid State Plan.

R414-9-7. Scope of Service Changes (SSC).

(1) A provider who wants an SSC rate consideration must provide required documentation, meet SSC requirements, and have a qualifying event. The provider must email documentation to MedicaidHealthCenter@utah.gov.

(2) Documentation must clearly detail the change in type, intensity, duration, and amount of services, and include additional documentation that the FQHC or RHC supports the request. An FQHC or RHC must also submit to the Department the Medicaid scope of services application.

(a) FQHCs or RHCs that submit retrospective cost information must submit a completed change in scope worksheet showing:

(i) costs by service type and totals with data from the most recently completed Medicare cost report;

(ii) calculation of total allowable billable visits with data from the Medicare cost report and detail of additional visits;

(iii) detail of costs and visits associated with the qualifying event; and

(iv) any additional cost information or documentation that the Department requests.

(b) For health centers that submit prospective cost information, a completed SSC worksheet showing:

(i) a budget for a future 12-month period that includes any prospective qualifying events;

(ii) a projection of total allowable billable visits;

(iii) documentation of additional costs associated with prospective qualifying events, with a description of how the estimates were determined to be reasonable; and

(iv) a narrative description of each qualifying event in the change in SSC.

(3) For health centers applying for their first SSC before January 1, 2025, qualifying events may include items from the previous eight years.

(4) For health centers applying for their first SSC after January 1, 2025, qualifying events may include items from the previous two years.

(5) For health centers that have already done an SSC, only qualifying events since the earlier approved change in scope may be submitted for consideration.

(6) The Department calculates an incremental cost for each visit by dividing incremental costs by total visits. The new PPS rate is calculated by adding the incremental cost for each visit to the current PPS rate. The Department applies other appropriate adjustments in accordance with the Medicaid State Plan.

(7) It is the responsibility of the FQHC or RHC to notify the Department of any increases or decreases in costs.

(8) General requirements for FQHCs or RHCs to complete an SSC change include the following:

(a) The Department must receive a complete request documentation package at least six months before the end of the FQHC and RHC fiscal year to change the next fiscal year's PPS rate. When an FQHC or RHC submits an SSC change without complete documentation, the request is returned without processing. The FQHC or RHC provider shall resubmit the entire request including the additional documentation. The date, in which a complete request with supporting documentation is received, is the submission date used for the SSC change.

(b) The effective date is the first day of the provider's fiscal year following the year in which the SSC is submitted, subject to the terms of Subsection (8)(a).

(c) The requested rate change from the SSC costs must exceed a 5% increase or decrease threshold from the current PPS Medicaid rate.

(d) The FQHC or RHC may not submit a request for an SSC change more than every two years. An exception may be allowed for the following:

(i) an HRSA-approved new access point; or

(ii) the SSC exceeds a 10% increase or decrease threshold.

(e) The Department shall deny requests to review SSC changes that go back more than eight years. Effective January 1, 2025, the Department shall deny requests to review SSC changes that go back more than two years.

(9) An FQHC or RHC must have a qualifying event to trigger an SSC change. The qualifying event may result in either an increase or decrease in services. The following are considered qualifying events if covered by Medicaid:

(a) increasing primary care and medical specialties such as cardiology and dermatology;

(b) adding or supplementing case management or care coordination for non-billable services;

(c) adding preventive dental or restorative dental surgery;

(d) x-ray that includes ultrasound, provided directly, but not through referral arrangement;

(e) medication-assisted treatment;

(f) behavioral health;

(i) adding behavioral health services and providers;

(ii) supplementing care team with behavioral health staff, such as community health workers and behaviorists who may not generate additional billable visits;

(g) substance use disorder treatment services;

(h) lab tests, in addition to rapid and CLIA-waived, including coronavirus rapid tests;

(i) obstetrical and gynecological services;

(j) distinct staff and services for social determinants of health interventions, such as non-medical factors that impact quality of life risks and health outcomes, which include food insecurities, housing instability, transportation barriers, and literacy levels;

(k) enabling services such as interpretation, financial counseling, diabetes, and education;

(l) providing direct optometry services;

(m) adding new or certified staff for chronic pain management;

(n) including clinical pharmacists;

(o) chiropractic care;

(p) physical therapy;

(q) complementary and alternative medicine; and

(r) an amendment to the Medicaid State Plan to remove a service that an FQHC or RHC has previously offered.

(10) Any increase or decrease in services under Subsection (9) may be a qualifying event.

(11) FQHC or RHCs that have a change in intensity, amount, or duration of the following services, if covered by Medicaid, would be considered a qualifying event:

(a) the provision of additional listed services or the deletion of a new type of service;

(b) telehealth;

(c) first-time implementation of an electronic medical record;

(d) new electronic medical record modules;

(e) remote patient monitoring;

(f) regulatory compliance through new rules and building a compliance infrastructure;

(g) population changes among groups such as the homeless, the elderly, and those with human immunodeficiency virus, acquired immunodeficiency syndrome, and other chronic diseases;

(h) an HRSA-approved change in the scope of project such as the addition of a new site;

(i) a mix of healthcare providers that includes treatment from a psychiatrist, infectious disease specialist, or other healthcare provider;

(j) public health emergencies;

(k) changing capital costs from a remodel, relocation, or establishing a new site;

(l) a new technological service or infrastructure that does not replace the current one; and

(m) costs associated with a teaching health center.

(12) The Department considers only the net cost of an SSC for payment if an SSC change is otherwise reimbursed.

KEY: Medicaid, facility, reimbursement
Date of Last Change: June 12, 2023
Notice of Continuation: July 27, 2018
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108