DMHF Rules Matrix 8-18-22

Rule Summary	Bulletin Publication	Effective
R414-15 Residents Personal Needs Fund (Five-Year Review); The Department will continue this rule because it requires long-term care facilities to manage and safeguard a resident's personal funds.	**7-15-22**	**6-21-22**
R414-514 Requirements for Moratorium Exception (Five-Year Review); The Department will continue this rule because it implements requirements that a Medicaid-certified nursing facility program must meet for certification of additional nursing care facility programs, or for certification of additional beds within an existing nursing care facility program.	**7-15-22**	**6-29-22**
R382-2 Electronic Personal Medical Records for the Children's Health Insurance Program (Five-Year Review); The Department will continue this rule because it implements the requirement to enroll a CHIP member in an electronic health information exchange and specifies the member's right to opt out.	**8-15-22**	**7-26-22**
R414-8 Electronic Personal Medical Records for the Medicaid Program (Five-Year Review); The Department will continue this rule because it implements the requirement to enroll a Medicaid member in an electronic health information exchange and specifies the member's right to opt out.	**8-15-22**	**7-26-22**
R414-14A Hospice Care (Repeal and Reenact); The purpose of this change is to update and clarify current Medicaid policy for hospice care services. As a result, all requirements of the repealed rule are reenacted in the proposed rule. In contrast to the repealed rule, this new rule streamlines hospice care policies by restructuring sections of the rule and removing operational details that belong in the hospice care provider manual.	**8-15-22**	**9-21-22**

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 November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-15**	**Filing ID: (Office Use Only)**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
Contact person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Residents Personal Needs Fund
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 26-18-3 requires the Department to implement the Medicaid program through administrative rules, which include the provision of long-term care services to facility residents. In addition, 42 CFR 483.10(ii)(B) requires facilities to deposit resident funds over $50 in a separate interest-bearing account.
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 requires long-term care facilities to manage and safeguard a resident's personal funds.

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:	Nate Checketts, Executive Director	**Date** (mm/dd/yyyy):	06/21/2022
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-15. Residents Personal Needs Fund.
R414-15-1. Introduction and Authority.

(1) This policy ensures proper administration of the personal funds of a Medicaid client who is a resident in a long term care facility. The administrative payee is responsible for using the beneficiary's benefits in his best interest. Flat rate reimbursement shall not be charged to personal funds. The flat rate shall cover the services specified in Attachment 4.19-D, Section 400 of the State Plan.

(2) This rule is authorized by Section 26-1-5 and 42 CFR 442 and 447.

R414-15-2. Definitions.

The definitions in R414-1 apply to this rule.

R414-15-3. Facility Responsibilities.

(1) For residents who are Medicaid clients, the administration and management of a long term care facility (the facility) must provide the resident, next of kin, or legal guardian:

(a) a written statement at the time of admission explaining:

(i) the resident's rights regarding personal funds; and

(ii) a list of services included in the basic per diem rate;

(b) access to a written record of all financial transactions involving the individual resident funds;

(c) a written itemized statement quarterly of all financial transactions involving the individual resident funds upon written request; and

(d) all funds that were given to the facility for safekeeping, including interest, within 30 days of the resident's discharge.

(2) The facility must notify the Social Security Administration office to have a representative payee appointed for residents who do not have a legal guardian, representative payee, or other authorized individual to manage their personal needs funds.

(3) The facility must serve as a temporary representative payee for the resident until the representative payee is appointed.

(4) The facility must allow the resident to access his funds for at least one hour during business hours.

(5) Upon request, the facility must return funds to the resident from an outside interest-bearing account within one business day.

(6) The facility shall deposit all funds in excess of $50.00:

(a) within 15 calendar days of receipt of the money;

(b) in an interest-bearing account that clearly indicates that the facility's interest is only fiduciary; and

(c) in a federally insured savings institution.

(7) The facility may deposit the resident's Social Security check into the facility's bank account if the personal need portion of the resident's check is transferred to the resident's account on the same day.

(8) The facility must distribute monthly the interest from the resident's interest-bearing accounts by either:

(a) maintaining separate savings accounts for each resident; or

(b) prorating the amount individually if funds are combined in one account for all residents.

(9) The facility may keep up to $50.00 of the resident's money in a non-interest-bearing account that is readily accessible to the resident.

(10) The facility must give any benefits to the resident either personally or through the resident's personal need fund unless there is a written authorization from the resident or legal guardian to do otherwise. This includes resident entitlements from Social Security Supplemental Income, government and private pensions, Veterans Administration, and other similar entitlement programs.

(11) The facility must provide the estate executor or administrator of a deceased resident with a written accounting of the resident's personal funds within 30 days of the resident's death. If the resident has not had an executor or administrator appointed, the facility must provide the accounting to:

(a) the resident's next of kin, legal guardian, representative payee, or other person the resident designated to manage his personal financial affairs while he was living; and

(b) the District Court in the county where the resident died.

(12) If the facility sells or leases the business, it must:

(a) provide the buyer or lessee with a written statement of all of the residents' monies and properties being transferred;

(b) obtain a signed receipt from the new owner or lessee before the sale or lease is final; and

(c) provide each resident's legal guardian, representative payee, or other person the resident authorized to manage his personal funds, a written accounting of all funds held by the facility before any transfer of ownership. The new owner or lessee shall assume full liability for all residents' personal needs accounts.

(13) For medical or supplemental security income recipients, the facility must provide written notification to the resident and the Department ten days before the resident's funds are about to exceed the amount that would

jeopardize his Medicaid eligibility.

(14) The facility must maintain the resident's personal funds for safekeeping if requested according to R414-15-4.

R414-15-4. Resident Personal Funds for Safekeeping.

The resident shall not be required to give his personal funds to the facility for safekeeping. If the resident (or legal guardian) requests this service of the facility, the request must be a written authorization.

KEY: medicaid
Date of Enactment or Last Substantive Amendment: January 13, 1998
Notice of Continuation: June 28, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5

State of Utah

Administrative Rule Analysis
Revised November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-514**	**Filing ID: (Office Use Only)**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
Contact person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Requirements for Moratorium Exception
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
This rule is authorized by Section 26-18-503, which allows the Department to renew, transfer, or increase Medicaid-certified programs. Additionally, Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules, and Section 26-1-5 grants the Department the authority to adopt these rules for implementation.
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 requirements that a Medicaid-certified nursing facility program must meet for certification of additional nursing care facility programs, or for certification of additional beds within an existing nursing care facility program.

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:	Nate Checketts, Executive Director	**Date** (mm/dd/yyyy)**:**	06/29/2022
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-514. Requirements for Moratorium Exception.
R414-514-1. Introduction and Authority.

(1) This rule implements requirements that a Medicaid-certified nursing facility program must meet for certification of additional nursing care facility programs, or for certification of additional beds within an existing nursing care facility program.

(2) This rule is authorized under Sections 26-18-3, 26-18-5, and 26-18-503.

R414-514-2. Requirements for Additional Nursing Care Facility Programs or Additional Beds Within an Existing Program.

(1) A Medicaid-certified nursing care facility program must meet the requirements of Section 26-18-503 to acquire additional nursing care facility programs or to acquire additional beds.

(2) Pursuant to Subsection 26-18-503(5), a nursing care facility program must provide all necessary information on the Utah Medicaid Nursing Facility Moratorium Exception Application. The Division of Medicaid and Health Financing (DMHF) shall return the application to the requestor if the application or supporting documentation is deficient.

(3) The notice date shall be the postmark date or other proof of delivery for the application mailed to DMHF.

(4) If DMHF receives an application for the Utah Medicaid Nursing Facility Moratorium Exception in a rural county, and a Medicaid-certified nursing facility program does not meet the quality standards pursuant to Subsection 26-18-503(5)(d)(v), the certified program may provide additional information under Subsection 26-18-503(9)(a)(ii). Any additional information submitted to DMHF must be postmarked or have other proof of delivery information within 14 days of the original notice from DMHF. Electronic mail (email) does not meet the notification requirement.

KEY: Medicaid

Date of Enactment or Last Substantive Amendment: December 1, 2017

Authorizing, and Implemented or Interpreted Law: 26-18-3; 26-18-503

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R382-2**	**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 84114-3101
Mailing address:	PO Box 143101
City, state and zip:	Salt Lake City, UT 84114-3101

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 agency.		

General Information

2. Rule catchline:
Electronic Personal Medical Records for the Children's Health Insurance Program
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 26-40-103 sets forth member rights and requirements in the electronic exchange of information under the Children's Health Insurance Program (CHIP). In addition, 42 CFR 457.348 requires CHIP to implement a secure, electronic interface with other medical assistance programs to make eligibility determinations.
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 the requirement to enroll a CHIP member in an electronic health information exchange and specifies the member's right to opt out.

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:**	07/24/2022
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R382. Health, Children's Health Insurance Program.
R382-2. Electronic Personal Medical Records for the Children's Health Insurance Program.
R382-2-1. Introduction and Authority.

This rule is promulgated under authority granted in Section 26-40-103, as last amended by Laws of Utah 2012, Chapters 28 and 369.

R382-2-2. Purpose.

This rule establishes requirements for enrolling Children's Health Insurance Program (CHIP) beneficiaries in the electronic exchange of clinical health information unless the beneficiary or the beneficiary's parent or legal guardian opts the beneficiary out.

R382-2-3. Definitions.

These definitions apply to Rule R382-2:

(1) "Technical specifications" means the technical specifications document published by the Utah Health Information Network (UHIN) that describes the variables and formats of the data to be submitted as well as submission directions and guidelines.

(2) "Program website" means the website for the Department of Health and Human Services Division of Integrated Healthcare, and the website for CHIP.

R382-2-4. Enrollment Notification.

(1) Before the enrollment process in the Clinical Health Information Exchange (CHIE), the Department provides notice of intent to enroll a CHIP beneficiary in CHIE and includes the right of a beneficiary to opt out.

(2) The Department provides additional education regarding the beneficiary's right to opt out on the program websites.

R382-2-5. Enrollment Process.

(1) The Department provides CHIE an enrollment file of CHIP beneficiaries.

(2) The enrollment file contains the succeeding month's CHIP enrollment.

(3) CHIE enrolls a CHIP beneficiary on the first day of the succeeding month.

(4) Technical specifications published by UHIN and the Department's operating agreement with CHIE describe detailed submission procedures and guidelines, including required data elements.

(5) The Department uses a secure format to transfer any enrollment files to CHIE.

R382-2-6. Exemptions.

(1) An individual's previous consent status in CHIE is honored by CHIE and is not overridden by the CHIP enrollment file.

KEY: CHIP, CHIE
Date of Last Change: July 11, 2022
Notice of Continuation: July 31, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40-103

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	R414-8	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 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
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 agency.		

General Information

2. Rule catchline:
Electronic Personal Medical Records for the Medicaid Program
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 26-18-3 sets forth member rights and requirements in the electronic exchange of information under the Medicaid program. In addition, 42 CFR 435.1200 requires Medicaid to implement a secure, electronic interface with other medical assistance programs to make eligibility determinations.
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 the requirement to enroll a Medicaid member in an electronic health information exchange and specifies the member's right to opt out.

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:**	07/24/2022
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, Health Care Financing, Coverage and Reimbursement Policy.
R414-8. Electronic Personal Medical Records for the Medicaid Program.
R414-8-1. Introduction and Authority.

This rule is promulgated under authority granted in Section 26-18-3, as last amended by Laws of Utah 2012, Chapters 28 and 242.

R414-8-2. Purpose.

This rule establishes requirements for enrolling Medicaid beneficiaries in the electronic exchange of clinical health information unless the individual opts out.

R414-8-3. Definitions.

These definitions apply to Rule R414-8:

(1) "Medicaid beneficiaries" mean individuals who receive assistance through the following programs:

(a) Medicaid;

(b) Primary Care Network;

(c) Utah's Premium Partnership for Health Insurance;

(d) Baby Your Baby;

(e) Cost sharing programs that include Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).

(2) "Technical Specifications" means the technical specifications document published by the Utah Health Information Network (UHIN) that describes the variables and formats of the data to be submitted as well as submission directions and guidelines.

(3) "Program Website" means the Department of Health, Department of Workforce Services, Division of Medicaid and Health Financing, Utah's Premium Partnership for Health Insurance, and Primary Care Network websites.

R414-8-4. Enrollment Notification.

(1) Prior to the enrollment process in the Clinical Health Information Exchange (cHIE), the Department will provide Notice of Intent to Medicaid beneficiaries in cHIE and the right of individuals to opt out.

(2) The Department will provide additional education regarding the individual's right to opt out on the program websites.

R414-8-5. Enrollment Process.

(1) The Department will provide cHIE an enrollment file of all Medicaid beneficiaries.

(2) The enrollment file will contain the succeeding month's Medicaid enrollment.

(3) cHIE will enroll Medicaid beneficiaries on the first day of the succeeding month.

(4) Submission procedures and guidelines, including required data elements, will be described in detail in the technical specifications published by UHIN and will be included in the Department's Operating Agreement with cHIE.

(5) The Department will use a secure format to transfer any enrollment files to cHIE.

R414-8-6. Exemptions.

(1) An individual's previous consent status in cHIE will be honored by cHIE and will not be overridden by the Medicaid enrollment file.

KEY: Medicaid, cHIE
Date of Enactment or Last Substantive Amendment: September 1, 2012
Notice of Continuation: July 28, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Repeal and Reenact		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-14A**	**Filing ID: 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 agency.		

General Information

2. Rule or section catchline:
Hospice Care
3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**
The purpose of this change is to update and clarify current Medicaid policy for hospice care services.
4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**
All requirements of the repealed rule are reenacted in the proposed rule. In contrast to the repealed rule, this new rule streamlines hospice care policies by restructuring sections of the rule and removing operational details that belong in the hospice care provider manual.

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 this change simply updates and clarifies current requirements for the hospice care program.
B) Local governments:
There is no impact on local governments because they neither fund nor determine eligibility for the hospice care program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no impact on small businesses as this change simply updates and clarifies current requirements for the hospice care program.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
There is no impact on non-small businesses as this change simply updates and clarifies current requirements for the hospice care program.
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 on Medicaid providers and Medicaid members as this change simply updates and clarifies current requirements for the hospice care program.
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 as this change simply updates and clarifies current requirements for the hospice care program.

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	**FY2023**	**FY2024**	**FY2025**
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	**FY2023**	**FY2024**	**FY2025**
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 S. Gruber, has reviewed and approved this fiscal analysis. Businesses will see neither costs nor revenue as this change simply updates and clarifies current requirements for the hospice program.

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-1-204	Section 26-18-3	

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**

A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	National Hospice and Palliative Care Organization
Publisher	National Hospice and Palliative Care Organization
Issue Date	
Issue or Version	2022

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

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:		09/14/2022
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

9. This rule change MAY become effective on:	09/21/2022
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, 302, 303, and 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:**	07/26/2022

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-14A. Hospice Care.

[~~R414-14A-1. Introduction and Authority.~~

~~This rule is authorized by Sections 26-1-5 and 26-18-3, and Pub L. No. 111-148 of the Affordable Care Act. It implements Medicaid hospice care services as found in 42 U.S.C. 1396d(o).~~

~~R414-14A-2. Definitions.~~

~~The definitions in Rule R414-1 apply to this rule. In addition:~~

~~(1) "Attending physician" means a physician who:~~

~~(a) is a doctor of medicine or osteopathy; and~~

~~(b) is identified by the client at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the client's medical care.~~

~~(2) "Cap period" means the 12-month period ending October 31 used in the application of the cap on reimbursement for inpatient hospice care as described in Subsection R414-14A-23(5).~~

~~(3) "Employee" means an employee of the hospice provider or, if the hospice provider is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" includes a volunteer under the direction of the hospice provider.~~

~~(4) "Hospice care" means care provided to terminally ill clients by a hospice provider.~~

~~(5) "Hospice provider" means a provider that is licensed under the provisions of Rule R432-750 and is primarily engaged in providing care to terminally ill individuals.~~

~~(6) "Physician" means a doctor of medicine or osteopathy who is licensed by the state of Utah.~~

~~(7) "Representative" means an individual who has been authorized under state law to make health care decisions, including initiating, continuing, refusing, or terminating medical treatments for a client who cannot make health care decisions.~~

~~(8) "Terminally ill" means the client has a medical prognosis to live no more than six months if the illness runs its normal course.~~

~~(9) "Adult" means a hospice client who is at least 21 years of age.~~

~~R414-14A-3. Client Eligibility Requirements.~~

~~(1) A client who is terminally ill may obtain hospice care pursuant to this rule.~~

~~(2) A client's certification of a terminal condition required for hospice eligibility must be based on a face-to-face assessment by a physician conducted no more than 90 days prior to the date of enrollment.~~

~~(3) A client dually enrolled in Medicare and Medicaid must elect the hospice benefit for both Medicare and Medicaid. The client must receive hospice coverage under Medicare. Election for the Medicaid hospice benefit provides the client coverage for Medicare co-insurance and coverage for room and board expenses while a resident of a Medicare-certified nursing facility, intermediate care facility for people with an intellectual disability (ICF/ID), or freestanding hospice facility.~~

~~(4) Primary diagnoses of "debility" and "adult failure to thrive" do not meet eligibility criteria for Medicaid hospice care if the patient does not have a least one other more definitive co-occurring principle terminal diagnosis.~~

~~R414-14A-4. Program Access Requirements.~~

~~(1) Hospice care may be provided only by a hospice provider licensed by the Department, that is Medicare certified in accordance with 42 CFR Part 418, and that is a Medicaid provider.~~

~~(2) A hospice provider must have a valid Medicaid provider agreement in place prior to initiating hospice care for Medicaid clients. The Medicaid provider agreement is effective on the date a Medicaid provider application is received in the Department and may not be made retroactive to an earlier date, including an earlier effective date of Medicare hospice certification.~~

~~(3) At the time of a change of ownership, the previous owner's provider agreement terminates as of the effective date of the change of ownership.~~

~~(4) The Department accepts all waivers granted to hospice agencies by the Centers for Medicare and Medicaid Services as part of the Medicare certification process.~~

~~(5) Hospice agencies participating in the Medicaid program shall provide hospice care in accordance with the requirements of 42 CFR Part 418.~~

~~R414-14A-5. Service Coverage.~~

~~Hospice care categories eligible for Medicaid reimbursement are the following:~~

~~(1) "Routine home care day" is a day in which a client who has elected to receive hospice care is at home and is not receiving continuous home care as defined in Subsection R414-14A-5(2). For purposes of routine home care day, extended stay residents of nursing facilities are considered at home.~~

~~(2) "Continuous home care day" is a day in which a client who has elected to receive hospice care receives a minimum of eight aggregate hours of care from the hospice provider during a 24-hour day, which begins and ends at midnight. The eight aggregate hours of care must be predominately nursing care provided by either a registered nurse or licensed practical nurse. Continuous home care is only furnished during brief periods of crisis in which a patient requires continuous care that is primarily nursing care to achieve palliation or management of acute medical symptoms. Extended stay residents of nursing facilities are not eligible for continuous home care day.~~

~~(3) "Inpatient respite care day" is a day in which the client who has elected hospice care receives short-term inpatient care when necessary to relieve family members or other persons caring for the client at home.~~

~~(4) "General inpatient care day" is a day in which a client who has elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that cannot be managed in a home or other outpatient setting. General inpatient care may be provided in a hospice inpatient unit, a hospital, or a nursing facility.~~

~~(5) "Room and Board" is medication administration, performance of personal care, social activities, routine and therapeutic dietary services, meal service including direct feeding assistance, maintaining the cleanliness of the client's room, assistance with activities of daily living, durable equipment, prescribed therapies, and all other services unrelated to care associated with the terminal illness that would be covered under the Medicaid State Plan nursing facility benefit.~~

~~R414-14A-6. Hospice Election.~~

~~(1) A client who meets the eligibility requirement for Medicaid hospice must file an election statement with a particular hospice. If the client cannot cognitively make informed health care decisions or is under 18 years of age, the client's legally authorized representative may file the election statement.~~

~~(2) Each hospice provider designs and prints his own election statement. The election statement must include the following:~~

~~(a) identification of the particular hospice that will provide care to the client;~~

~~(b) the client's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the client's terminal illness;~~

~~(c) for adult clients, acknowledgment that the client waives certain Medicaid services as set forth in Section R414-14A-9;~~

~~(d) acknowledgment that the client or representative may revoke the election of the hospice benefit at any time in the future and therefore become eligible for Medicaid services waived at the time of hospice election as set forth in Section R414-14A-8; and~~

~~(e) the signature of the client or representative.~~

~~(3) The effective date of the election may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement~~

~~(4) An election to receive hospice care remains effective through the initial election period and through the subsequent election periods without a break in care as long as the client:~~

~~(a) remains in the care of a hospice;~~

~~(b) does not revoke the election; and~~

~~(c) is not discharged from the hospice.~~

~~(5) The hospice provider must notify the Department at the time a Medicaid client selects the hospice benefit, including selecting the hospice provider under a change of designated hospice. The notification must include a copy of the hospice election statement and the physician's certification of terminal illness for hospice care. Authorization for reimbursement of hospice care begins no earlier than the date notification is received by the Department for an eligible Medicaid client, except as provided in Section R414-14A-20.~~

~~(6) Subject to the conditions set forth in this rule, a client may elect to receive hospice care during one or more of the following election periods:~~

~~(a) an initial 90-day period;~~

~~(b) a subsequent 90-day period; or~~

~~(c) an unlimited number of subsequent 60-day periods.~~

~~(7) The Department may only grant prior authorization for hospice care in alignment with the election periods defined in Subsection R414-14A-6(6).~~

~~R414-14A-7. Change in Hospice Provider.~~

~~(1) A client or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.~~

~~(2) The change of the designated hospice is not a revocation of the election for the period in which it is made.~~

~~(3) To change the designation of hospice provider, the client must file, with the hospice provider from which care has been received and with the newly designated hospice provider, a statement that includes the following information:~~

~~(a) the name of the hospice provider from which the client has received care;~~

~~(b) the name of the hospice provider from which the client plans to receive care; and~~

~~(c) the date the change is to be effective.~~

~~(4) The client must file the change on or before the effective date.~~

~~R414-14A-8. Revocation and Re-election of Hospice Services.~~

~~(1) A client or legal representative may voluntarily revoke the client's election of hospice care at any time during an election period.~~

~~(2) To revoke the election of hospice care, the client or representative must file a statement with the hospice provider that includes the following information:~~

~~(a) a signed statement that the client or representative revokes the client's election for Medicaid coverage of hospice care.~~

~~(b) the date that the revocation is to be effective, which may not be earlier than the date that the revocation is made; and~~

~~(c) an acknowledgment signed by the patient or the patient's representative that the patient will forfeit Medicaid hospice coverage for any remaining days in that election period.~~

~~(3) Upon revocation of the election of Medicaid coverage of hospice care for a particular election period, a client:~~

(a) is no longer covered under Medicaid for hospice care;
(b) resumes Medicaid coverage for the benefits waived under Section R414-14A-9 (for adult clients); and
(c) may at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.
(4) If an election has been revoked, the client or his representative may at any time file an election in accordance with this rule for any other election period that is still available to the client.
(5) Hospice providers may not encourage adult clients to temporarily revoke hospice services solely for the purpose of avoiding financial responsibility for Medicaid services that have been waived at the time of hospice election as described in Section R414-14A-9.
(6) Hospice providers must send notification to the Department within ten calendar days that a client has revoked hospice benefits. Notification must include a copy of the revocation statement signed by the client or the client's legal representative.

R414-14A-9. Rights Waived to Some Medicaid Services for Adult Clients.
(1) For the duration of an election for hospice care, an adult client waives all rights to Medicaid for the following services:
(a) hospice care provided by a hospice other than the hospice designated by the client, unless provided under arrangements made by the designated hospice; and
(b) any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or are duplicative of hospice care except for services:
(i) provided by the designated hospice;
(ii) provided by another hospice under arrangements made by the designated hospice; and
(iii) provided by the client's attending physician if the services provided are not otherwise covered by the payment made for hospice care.
(2) Medicaid services for illnesses or conditions not related to the client's terminal illness are not covered through the hospice program but are covered when provided by the appropriate provider.

R414-14A-10. Concurrent Care for Clients Under 21 Years of Age.
(1) For the duration of the election of hospice care, clients under 21 years of age may only receive hospice care which is provided by the designated hospice, or that has been provided under arrangements made by the designated hospice.
(2) Clients under 21 years of age who elect to receive Medicaid hospice care may also receive concurrent Medicaid State Plan treatment for the terminal illness and other related conditions.
(3) For life prolonging treatment rendered to clients under 21 years of age, Medicaid shall reimburse the appropriate Medicaid enrolled medical care providers directly through the usual and customary Medicaid billing procedures. Hospice providers are not responsible to reimburse medical care providers for life prolonging treatment rendered to hospice clients who are under 21 years of age.
(4) Each pediatric hospice provider shall develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care to clients who are under 21 years of age. All staff members and volunteers who provide pediatric hospice care must receive the training before they provide hospice care services, and at least annually thereafter. The training shall include the following pediatric specific elements:
(a) Growth and development;
(b) Pediatric pain and symptom management;
(c) Loss, grief and bereavement for pediatric families and the child;
(d) Communication with family, community and interdisciplinary team;
(e) Psycho-social and spiritual care of children;
(f) Coordination of care with the child's community.
(5) For pediatric care, the Hospice Program shall adopt the National Hospice and Palliative Care Organization's (NHPCO) Standards for Hospice Programs.

R414-14A-11. Notice of Hospice Care in a Nursing Facility, ICF/ID, or Freestanding Inpatient Hospice Facility.

(1) The hospice provider must notify the Department at the time a Medicaid client residing in a Medicare certified nursing facility, a Medicaid-certified ICF/ID, or a Medicare freestanding inpatient hospice facility elects the Medicaid hospice benefit or at the time a Medicaid client who has elected the Medicaid hospice benefit is admitted to a Medicare certified nursing facility, a Medicaid certified ICF/ID, or a Medicare freestanding inpatient hospice facility.

(2) The notification must include a prognosis of the time the client will require skilled nursing facility services under the hospice benefit.

(3) Except as provided in Section R414-14A-20, reimbursement for room and board begins no earlier than the date the hospice provider notifies the Department that the client has elected the Medicaid hospice benefit.

R414-14A-12. Notice of Independent Attending Physician.

The hospice provider must notify the Department at the time a Medicaid client designates an attending physician who is not a hospice employee.

R414-14A-13. Extended Hospice Care.

(1) Adult patients who accumulate 12 or more consecutive months of hospice benefits are subject to an independent utilization review by a physician who is not affiliated with the hospice agency. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care. 12 consecutive months means 12 months in a row wherein a hospice provides Medicaid hospice care during any portion of each month.

(2) If Medicare determines that a patient is no longer eligible for Medicare reimbursement for hospice services, the patient will no longer be eligible for Medicaid reimbursement for hospice services. Providers must immediately notify Medicaid upon learning of Medicare's determination. Medicaid reimbursement for hospice services will cease the day after Medicare notifies the hospice provider that the client is no longer eligible for hospice care.

R414-14A-14. Provider Initiated Discharge from Hospice Care.

(1) The hospice provider may not initiate discharge of a patient from hospice care except in the following circumstances:

(a) the patient moves out of the hospice provider's geographic service area or transfers to another hospice provider by choice;

(b) the hospice determines that the patient is no longer terminally ill; or

(c) the hospice provider determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's behavior (or the behavior of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

(2) The hospice provider must carry out the following activities before it seeks to discharge a patient for cause:

(a) advise the patient that a discharge for cause is being considered;

(b) make a diligent effort to resolve the problem that the patient's behavior or situation presents;

(c) ascertain that the discharge is not due to the patient's use of necessary hospice services; and

(d) document the problem and efforts to resolve the problem in the patient's medical record.

(3) Before discharging a patient for any reason listed in Subsection R414-14A-14(1), the hospice provider must obtain a physician's written discharge order from the hospice provider's medical director. If a patient also has an attending physician, the hospice provider must consult the physician before discharge and the attending physician must include the review and decision in the discharge documentation.

(4) A client, upon discharge from the hospice during a particular election period, for reasons other than immediate transfer to another hospice:

(a) is no longer covered under Medicaid for hospice care;

~~(b) resumes Medicaid coverage of the benefits waived during the hospice coverage period; (for adult clients); and~~

~~(c) may at any time elect to receive hospice care if the client is again eligible to receive the benefit in the future.~~

~~(5) The hospice provider must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change if that patient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because the patient is no longer terminally ill.~~

~~R414-14A-15. Hospice Room and Board Service.~~

~~If a client residing in a nursing facility, ICF/ID or a freestanding hospice inpatient unit elects hospice care, the hospice provider and the facility must have a written agreement under which the total care of the individual must be specified in a comprehensive service plan, the hospice provider is responsible for the professional management of the client's hospice care, and the facility agrees to provide room and board and services unrelated to the care of the terminal condition to the client. The agreement must include:~~

~~(1) identification of the services to be provided by each party and the method of care coordination to assure that all services are consistent with the hospice approach to care and are organized to achieve the outcomes defined by the hospice plan of care;~~

~~(2) a stipulation that Medicaid services may be provided only with the express authorization of the hospice;~~

~~(3) the manner in which the contracted services are coordinated, supervised and evaluated by the hospice provider;~~

~~(4) the delineation of the roles of the hospice provider and the facility in the admission process; needs assessment process, and the interdisciplinary team care conference and service planning process;~~

~~(5) requirements for documenting that services are furnished in accordance with the agreement;~~

~~(6) the qualifications of the personnel providing the services; and~~

~~(7) the billing and reimbursement process by which the nursing facility will bill the hospice provider for room and board and receive payment from the hospice provider.~~

~~(8) In cases in which nursing facility residents revoke their hospice benefits, it is the responsibility of the hospice provider to notify the nursing facility of the revocation. The notice must be in writing and the hospice provider must provide it to the nursing facility on or before the revocation date.~~

~~R414-14A-16. In Home Physician Services.~~

~~In-home physician visits by the attending physician are authorized for hospice clients if the attending physician determines that direct management of the client in the home setting is necessary to achieve the goals associated with a hospice approach to care.~~

~~R414-14A-17. Continuous Home Care.~~

~~When the hospice provider determines that a patient requires at least eight hours of primarily nursing care in order to manage an acute medical crisis, the hospice provider will maintain documentation to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. Continuous home care is a covered benefit only as necessary to maintain the terminally ill client at home.~~

~~R414-14A-18. General Inpatient Care.~~

~~(1) General inpatient care is authorized without prior authorization for an initial ten calendar day length of stay. Prior authorization is required for any additional general inpatient care days during the same stay to verify that the client's needs meet the requirements for general inpatient care. If a hospice provider requests additional days, the subsequent requests are subject to clinical review and approval by qualified Department staff.~~

(2) General inpatient care days may not be used due to the breakdown of the primary care giving living arrangements or the collapse of other sources of support for the recipient.

(3) Prior authorization for additional days beyond the initial ten calendar day stay must be obtained before the hospice care is provided, except as allowed in Section R414-14A-20.

R414-14A-19. Inpatient Respite Care.

When the hospice provider determines that a patient requires a short-term inpatient respite stay in order to relieve the family members or other persons caring for the client at home, the hospice provider will maintain documentation to support the requirement that the services provided were reasonable and necessary to relieve a particular caregiver situation. Inpatient respite care may not be reimbursed for more than five consecutive days at a time. Inpatient respite care may not be reimbursed for a patient residing in a nursing facility, ICF/ID, or freestanding hospice inpatient unit.

R414-14A-20. Notification and Prior Authorization Grace Periods.

(1) If a new patient is already Medicaid eligible upon admission to hospice care, the hospice provider must submit a prior authorization request form to the Department in order to receive reimbursement for hospice services it renders, except in the following circumstances:

(a) During weekend, holidays, and after regular Department business hours, a hospice provider may begin service to a new Medicaid hospice enrollee, including covering room and board, or initiate a different hospice care requiring prior authorization for a grace period up to ten calendar days before notifying the Department;

(b) Before the end of the ten calendar day grace period, the hospice provider must complete and submit the prior authorization request form to the Department in order to receive reimbursement for hospice services it renders;

(c) If the hospice provider does not submit the prior authorization request form timely, the Department will not reimburse the provider for the care that it renders before the date that the form is received.

(d) The hospice provider must complete and submit with the prior authorization request, the form for independent physician review when an adult patient reaches 12 consecutive months in hospice care. The Department shall deny the prior authorization request if the provider does not include this form with the other required documents, or if this form does not indicate the patient meets ongoing eligibility criteria for Medicaid hospice care.

R414-14A-21. Post-Payment for Services Provided While in Medicaid-Pending Status.

(1) If a new client is not Medicaid eligible upon admission to hospice services but becomes Medicaid eligible at a later date, the Department will reimburse a hospice provider retroactively to allow the hospice eligibility date to coincide with the client's Medicaid eligibility date if:

(a) the Department determines that the client met Medicaid eligibility requirements at the time the service was provided;

(b) the hospice care met the prior authorization criteria at the time of delivery; and

(c) the hospice provider reimburses the Department for care related to the client's terminal illness delivered by other Medicaid providers during the retroactive period.

(2) The hospice provider must provide a copy of the initial care plan and any other documentation to the Department adequate to demonstrate the hospice care met prior authorization criteria at the time of delivery.

R414-14A-22. Hospice Care Reimbursement.

(1) The Department shall provide payment for hospice care in accordance with the methodology set forth in the Utah Medicaid State Plan.

(2) A hospice provider may not charge a Medicaid client for a service that the client is entitled to receive under Medicaid.

(3) Medicaid reimbursement to a hospice provider for services provided during a cap period is limited to the cap amount specified in Subsection R414-14A-23(5).

(4) Medicaid does not apply the aggregate caps used by Medicare.

~~(5) The Department provides payment for hospice care on the basis of the geographic location where the service is provided as described in the Medicaid State Plan.~~

~~(6) Routine home care, continuous home care, general inpatient care, inpatient respite care services, and hospice room and board, are reimbursable to the hospice provider only.~~

~~(7) Hospice general inpatient care and inpatient respite care are not reimbursed by Medicaid for services provided in a Veterans Administration hospital or military hospital.~~

~~**R414-14A-23. Payment for Hospice Care Categories.**~~

~~(1) The Department establishes payment amounts for the following categories:~~

~~(a) Routine home care.~~

~~(b) Continuous home care.~~

~~(c) Inpatient respite care.~~

~~(d) General inpatient care.~~

~~(e) Room and Board service.~~

~~(2) The Department reimburses the hospice provider at the appropriate payment amount for each day for which an eligible Medicaid recipient is under the hospice's care.~~

~~(3) The Medicaid reimbursement covers the same services and amounts covered by the equivalent Medicare reimbursement rate for comparable service categories.~~

~~(4) The Department makes payment according to the following procedures:~~

~~(a) Payment is made to the hospice for each day during which the client is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day.~~

~~(b) Payment is made for only one of the categories of hospice care described in Subsection R414-14A-23(1) for any particular day.~~

~~(c) On any day in which the client is not an inpatient, the Department pays the hospice provider the routine home care rate, unless the client receives continuous home care as provided in Subsection R414-14A-5(2) for a period of at least eight hours. In that case, the Department pays a portion of the continuous home care day rate in accordance with Subsection R414-14A-23(4)(d).~~

~~(d) The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The number of hours of continuous care provided during a continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of licensed nursing care must be furnished on a particular day to qualify for the continuous home care rate.~~

~~(e) Subject to the limitations described in Subsection R414-14A-23(5), on any day on which the client is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the client is discharged. For the day of discharge, the appropriate home care rate is paid unless the client dies as an inpatient. In the case where the client dies as an inpatient, the inpatient rate (general or respite) is paid for the discharge day. Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than five days at a time.~~

~~(5) Payment for inpatient care is limited as follows:~~

~~(a) The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid clients not exceed 20 % of the total days for which these clients had elected hospice care. Clients afflicted with AIDS are excluded when calculating inpatient days. For a client who is under 21 years of age, an inpatient stay in a hospital for the purpose of receiving life prolonging treatment for the terminal illness is not counted toward the cap on reimbursement for inpatient hospice care.~~

~~(b) At the end of a cap period, the Department calculates a limitation on payment for inpatient care for each hospice to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid clients by the hospice.~~

~~(c) If the number of days of inpatient care furnished to Medicaid clients is equal to or less than 20% of the total days of hospice care to Medicaid clients, no adjustment is necessary.~~

(d) If the number of days of inpatient care furnished to Medicaid clients exceeds 20% of the total days of hospice care to Medicaid clients, the total payment for inpatient care is determined in accordance with the procedures specified in Subsection R414-14A-23(5)(e). That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice.

(e) If a hospice exceeds the number of inpatient care days described in Subsection R414-14A-23(5)(d), the total payment for inpatient care is determined as follows:

(i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicaid clients.

(ii) Multiply this ratio by the total reimbursement for inpatient care made by the Department.

(iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.

(iv) Sum the amounts calculated in Subsection R414-14A-23(5)(e)(ii) and (iii).

(6) The hospice provider may request an exception to the inpatient care payment limitation if the hospice provider demonstrates the volume of Medicaid enrollees during the cap period was insufficient to reasonably achieve the required 20% ratio.

R414-14A-24. Payment for Physician Services.

(1) The following services performed by hospice physicians are included in the rates described in Sections R414-14A-22 and 23:

(a) General supervisory services of the medical director.

(b) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For services not described in Subsection R414-14A-24(1), direct care services related to the terminal illness or a related condition provided by hospice physicians are reimbursed according to the Medicaid reimbursement fee schedule for physician services. Services furnished voluntarily by physicians are not reimbursable.

(3) Services of the client's attending physician, including in-home services, are reimbursed according to the Medicaid fee schedule for State Plan physician services. Services furnished voluntarily by physicians are not reimbursable.

R414-14A-25. Hospice Payment Covers Special Modalities.

No additional Medicaid payment will be made for chemotherapy, radiation therapy, and other special modalities of care for palliative purposes regardless of the cost of the services.

R414-14A-26. Payment for Nursing Facility, ICF/ID, and Freestanding Inpatient Hospice Unit Room and Board.

(1) For clients in a nursing facility, ICF/ID, or a freestanding hospice inpatient unit who elect to receive hospice care from a Medicaid enrolled hospice provider, Medicaid will pay the hospice provider an additional per diem for routine home care services to cover the cost of room and board in the facility. For nursing facilities and ICFs/ID, the room and board rate is 95 % of the amount that the Department would have paid to the nursing facility or ICF/ID provider for that client if the client had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 95% of the statewide average paid by Medicaid for nursing facility services.

(a) For clients under 21 years of age, the room and board rate is 100% of the amount that the Department would have paid to the nursing facility or ICF/ID for that client if the client had not elected to receive hospice care.

(2) The Department shall reimburse the hospice provider for room and board. Upon receiving payment for room and board, the hospice provider shall reimburse the nursing facility. The reimbursement is payment in full for the services described in Section R414-14A-15. The facility cannot bill Medicaid separately.

(3) If a hospice enrollee in a nursing facility, ICF/ID, or a freestanding hospice inpatient unit has a monetary obligation to contribute to his cost of care in the facility, the facility must collect and retain the

~~contribution. The hospice must reimburse the facility the reduced amount received from Medicaid directly or from a Medicaid Health Plan.~~

~~R414-14A-27. Limitation on Liability for Certain Hospice Coverage Denials.~~

~~If the hospice provider or the Department determines that a client is not terminally ill while receiving hospice care under this rule, the client is not responsible to reimburse the Department. If the Department denies reimbursement to the hospice provider, the hospice provider may not seek reimbursement from the client.~~

~~R414-14A-28. Medicaid Health Plans and Hospice.~~

~~(1) If a Medicaid-only client is enrolled in a Medicaid health plan, the hospice selected by the client must have a contract with the health plan. The health plan is responsible to reimburse the hospice for hospice care. The Department will not directly reimburse a hospice provider for a Medicaid-only client covered by a health plan.~~

~~(2) If a Medicaid-only client enrolled in a health plan elects hospice care before being admitted to a nursing facility, ICF/ID, or a freestanding hospice inpatient unit, the health plan is responsible to reimburse the hospice provider for both the hospice care and the room and board until the client is disenrolled from the health plan by the Department. At the point the health plan determines that the enrollee will require care in the nursing facility for greater than 30 days, the health plan will notify the Department of the prognosis of extended nursing facility services. The Department will schedule disenrollment from the health plan to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities.~~

~~(3) If a hospice enrollee is covered by Medicare for hospice care, the Medicaid health plan is responsible for the health plan's payment rate less any amount paid by Medicare and other payors. The health plan is responsible for payment even if the Medicare covered service is rendered by an out-of-plan provider or was not authorized by the health plan.~~

~~(4) The health plan is responsible for room and board expenses of a hospice enrollee receiving Medicare hospice care while the client is a resident of a Medicare-certified nursing facility, ICF/ID, or freestanding hospice facility until the client is disenrolled from the health plan by the Department. On the 31st day, the client is disenrolled from the health plan and enrolled in the Medicaid fee-for-service hospice program. At the point the Department determines that the enrollee will require care in the nursing facility for greater than 30 days, the Department will schedule disenrollment from the health plan to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities. The room and board expenses will be set in accordance with Section R414-14A-26.~~

~~(5) The hospice provider is responsible for determining if an applicant for hospice care is covered by a Medicaid health plan prior to enrolling the client, for coordinating services and reimbursement with the health plan during the period the client is receiving the hospice benefit, and for notifying the health plan when the client disenrolls from the hospice benefit.~~

~~R414-14A-29. Marketing by Hospice Providers.~~

~~Hospice providers may not engage in unsolicited direct marketing to prospective clients. Marketing strategies shall remain limited to mass outreach and advertisements, except when a prospective client or legal representative explicitly requests information from a particular hospice provider. Hospice providers shall refrain from offering incentives or other enticements to persuade a prospective client to choose that provider for hospice care.~~

~~R414-14A-30. Medicaid 1915c HCBS Waivers and Hospice.~~

~~(1) For hospice enrollees covered by a Medicaid 1915c Home and Community-Based Services Waiver, hospice providers shall provide medically necessary care that is directly related to the patient's terminal illness.~~

~~(2) The waiver program may continue to provide services that are:~~

~~(a) unrelated to the client's terminal illness and;~~

~~(b) assessed by the waiver program as necessary to maintain safe residence in a home or community-based setting in accordance with waiver requirements.~~

(3) The waiver case management agency and the hospice case management agency shall meet together upon commencement of hospice services to develop a coordinated plan of care that clearly defines the roles and responsibilities of each program.]

R414-14A-1. Introduction and Authority.

This rule defines the scope of hospice care services available to Medicaid members. Authorization of this rule is in accordance with Sections 26-1-5 and 26-18-3, 42 CFR 418, Section 1861(dd) and Section1905(o) of the Social Security Act, 42 U.S.C. 1396d, and Pub L. No. 111 148 of the Affordable Care Act.

R414-14A-2. Definitions.

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

(1) "Adult" means a member who is 21 years of age or older.

(2) "Attending physician" means:

(a) an individual identified by the member when the member elects to receive hospice care as having the most significant role in determining and delivering the member's medical care; and

(b) a healthcare practitioner who is:

(i) a physician who is a doctor of medicine or osteopathy; or

(ii) a nurse practitioner or physician assistant who meets proper training, education, and experience requirements within their scope of licensing.

(3) "Cap period" means the 12-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in 42 CFR 418.309.

(4) "Consecutive months" means any number of months in a row wherein a hospice agency provides hospice care under the Medicaid benefit, including any portion of a month.

(5) "Continuous home care day" means a day in which a member, who has elected to receive hospice care at home, receives a minimum of eight aggregate hours of care from the hospice provider during a 24-hour day, which begins and ends at midnight. The eight aggregate hours of care must be predominantly nursing care provided by either a registered nurse or licensed practical nurse.

(6) "General inpatient care day" means a day when a member with elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that is not manageable in the member's place of residence or another outpatient setting.

(7) "Hospice agency" means an agency licensed under Rule R432-750 and is primarily engaged in providing hospice care to terminally ill individuals.

(8) "Inpatient respite care day" means a day when a member with elected hospice care receives short-term inpatient care necessary to relieve family members or other persons caring for the member at their place of residence.

(9) "Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care addresses physical, intellectual, emotional, social, and spiritual needs while facilitating patient autonomy, access to information, and choice.

(10) "Pediatric" means a member who is under 21 years of age.

(11) "Pediatric hospice agency" means an enrolled hospice agency that has trained employees in providing hospice care to patients who are younger than 21 years of age.

(12) "Representative" means an individual who is authorized under state law to make health care decisions on behalf of a member, including initiating, continuing, refusing, or terminating medical treatments for a member who cannot make these decisions.

(13) "Terminally ill" means a medical prognosis to live no more than six months if the illness runs its ordinary course.

R414-14A-3. Member Eligibility Requirements.

(1) Hospice benefits are available to categorically and medically needy Medicaid-eligible individuals.

(2) A member, or representative if the member is incapacitated, must file an election statement with a hospice agency when choosing to use the hospice benefit.

(3) A member who has been assessed and provided with a written certification of terminal illness from a physician may obtain hospice services in accordance with 42 CFR 418.22.

(4) A member dually enrolled in Medicare and Medicaid must elect the hospice benefit for both Medicare and Medicaid in accordance with 42 CFR 418.21 and 418.24. The member must receive hospice coverage under Medicare primarily. Election for the Medicaid hospice benefit provides the member coverage for Medicare coinsurance and room and board expenses while admitted to a Medicare-certified nursing facility, intermediate care facility for people with an intellectual disability ICF/ID, or freestanding hospice facility.

(5) A primary diagnosis of debility or failure to thrive in adults does not meet eligibility criteria for the coverage of hospice services.

R414-14A-4. Program Access Requirements.

(1) The hospice agency must operate and furnish services in compliance with applicable federal, state, and local laws and regulations related to the health and safety of patients.

(2) The hospice agency must be licensed with the state, Medicare-certified in accordance with 42 CFR 418, and an enrolled Medicaid provider before initiating hospice services. At the time of a change of ownership, the previous owner's provider agreement terminates as of the effective date of the change of ownership.

(3) Medicaid accepts waivers granted to hospice agencies by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicare certification process.

(4) If a member who resides in a nursing facility, ICF/ID, or a freestanding hospice inpatient facility elects to receive hospice benefits, the hospice agency and the facility must have a written agreement in which a comprehensive service plan specifies the total care of the member.

(a) The agreement must outline that the hospice agency is responsible for the professional management of the member's hospice care.

(b) The facility agrees to provide room and board and services unrelated to the care of the terminal condition of the member.

(5) The agreement must include the following:

(a) identification of the services to be provided by the hospice agency and the facility as well as the method of care coordination to ensure services are consistent with the hospice approach to care and are organized to achieve the outcomes defined by the hospice plan of care;

(b) a stipulation that services may be provided only with the express authorization of the hospice agency;

(c) how the contracted services are coordinated, supervised, and evaluated by the hospice agency;

(d) the delineation of the roles of the hospice agency and the facility in the admission process that includes an assessment process, an interdisciplinary team care conference, and a service planning process;

(e) requirements for documenting that services are furnished following the agreement;

(f) the qualifications of the personnel providing the services; and

(g) the billing and reimbursement process by which the facility will bill the hospice agency for room and board to receive reimbursement from the hospice agency.

R414-14A-5. Service Coverage.

(1) Hospice service coverage includes medically necessary services as outlined in Subsection R414-1-2(18).

(2) Continuous home care is limited to alleviate or manage acute medical symptoms.

(a) Extended stay residents of nursing facilities are not eligible for continuous home care days.

(b) Continuous home care is covered only as required to maintain the terminally ill member at the member's place of residence.

(c) The hospice agency shall maintain documentation to support the requirement that the service was medically necessary and complied with an established plan of care.

(3) Medicaid covers hospice room and board in a nursing facility, ICF/ID, or a freestanding hospice inpatient facility and includes:

(a) medication administration;

(b) personal care;

(c) social activities;

(d) routine and therapeutic dietary services, including direct feeding assistance;
(e) maintaining the cleanliness of the member's room;
(f) assistance with activities of daily living (ADLs);
(g) durable medical equipment;
(h) medical supplies; and
(i) prescribed therapies.

(4) Other services unrelated to care associated with the terminal illness are covered under the Utah Medicaid State Plan nursing facility benefit.

(5) If a member who resides in a nursing facility revokes one's hospice benefits, the hospice agency shall notify the facility of the revocation. The following notification requirements apply:
(a) the notice must be in writing; and
(b) the hospice agency must provide the notification to the facility on or before the revocation date.

(6) A member may receive general inpatient care provided in a hospice inpatient unit, a hospital, or a nursing facility. General inpatient care days may not be used due to the breakdown of the primary caregiving living arrangements or the collapse of other sources of support for the member.

(7) Any change in hospice agencies must adhere to the requirements of 42 CFR 418.30. The member or the member's legal representative shall file the change with both the hospice agency from which care has been received and with the newly designated hospice agency on or before the effective date.

(8) A member or legal representative may voluntarily revoke the member's election of hospice benefits. The member or the member's representative must sign an acknowledgement that the member will forfeit hospice service coverage for any remaining days in the election period.

(9) Medicaid does not separately cover modalities for palliative purposes as this is the responsibility of the hospice agency. For the duration of an election for hospice care services, an individual waives rights to Medicaid payments for the following services.
(a) Hospice care provided by a hospice agency other than the hospice agency designated by the individual, unless provided under arrangements made by the designated hospice agency.
(b) Services for illnesses or conditions unrelated to the member's terminal illness, as these services are covered ancillary to hospice benefits when provided by an appropriate provider or facility.
(c) Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, or a related condition, or that are equivalent to hospice care except for services provided by:
(i) the designated hospice agency;
(ii) another hospice agency under arrangements made by the designated hospice agency; and
(iii) the individual's attending physician if that physician is not an employee of the designated hospice agency or receiving compensation from the hospice agency for those services.

(10) The following applies for concurrent care for members under 21 years of age.
(a) For the duration of the election of hospice care, pediatric members may only receive hospice care that is:
(i) provided by the designated hospice agency; or
(ii) provided under arrangements made by the designated hospice agency.
(b) Pediatric members who elect to receive hospice care services may also receive concurrent Medicaid State Plan services for the terminal illness and other related conditions.
(c) Medicaid does not separately cover any modalities for palliative purposes as this is the responsibility of the hospice agency.
(i) Hospice agencies that provide services outside of the hospice benefit shall report directly to Medicaid for coverage.
(ii) Hospice agencies are not responsible for reimbursing other providers or facilities for life-prolonging services given to pediatric members.
(d) Hospice agencies that perform pediatric care shall develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care services. Staff members and volunteers who provide pediatric hospice care services must receive training before providing hospice services and at least annually thereafter.

(11) The training shall include the following pediatric-specific elements:

(a) growth and development;
(b) pediatric pain and symptom management;
(c) loss, grief, and bereavement for pediatric families and the child;
(d) communication with family, community, and interdisciplinary team;
(e) psychosocial and spiritual care of children; and
(f) coordination of care with the child's community.
(g) Medicaid incorporates by reference standards for pediatric hospice care services set forth by the National Hospice and Palliative Care Organization, 2022.

(12) The hospice agency is responsible for notifying Medicaid when a member is enrolled in hospice care, when a member is discharged from hospice care, when a member moves into a long-term care facility, ICF/ID, or freestanding inpatient hospice facility, or when there has been a change in hospice agencies.

(13) If Medicare determines that a member is no longer eligible for Medicare coverage of hospice care services, then the member no longer qualifies for Medicaid coverage of hospice services. Subsequently, hospice agencies shall immediately notify Medicaid of the members change in eligibility upon learning of Medicare's determination. Medicaid coverage for hospice care services ends the day after Medicare notifies the hospice agency that the member is no longer eligible for hospice care.

(14) Hospice agencies may not initiate the discharge of a member from hospice unless the member meets the circumstances outlined in 42 CFR 418.26.

(15) Inpatient respite care follows special coverage requirements, which are outlined in 42 CFR 418.204 (b)(2).
(a) Medicaid does not cover inpatient respite care for members who reside in nursing facilities, ICF/IDs, or freestanding hospice inpatient units.
(b) Medicaid may not provide consecutive coverage for inpatient respite care for more than five days at a time.

R414-14A-6. Reimbursement.

(1) Hospice agency and provider reimbursement for hospice services are made in accordance with the methodologies outlined in the Utah Medicaid State Plan.

(2) Reimbursement for services provided during a capped period is limited to the cap amount and Medicaid does not apply the aggregate caps used by Medicare.

(3) Services provided in a veteran's administration hospital or military hospital are not reimbursable.

(4) The hospice provider may request an exception to the inpatient care reimbursement limitation if the hospice provider demonstrates the volume of Medicaid enrollees during the cap period was insufficient to reasonably achieve the required 20% ratio.

(5) Direct care provided by a hospice physician, related to the terminal illness or a related condition, are separately reimbursable.

(6) Service provided by members' attending physicians are separately reimbursable.

(7) Medicaid reimbursement covers the same services and amounts covered by the equivalent Medicare reimbursement rate for comparable service categories.

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