DMHF Rules Matrix 5-18-23

Rule Summary	Bulletin Publication	Effective
R414-517 Inpatient Hospital Provider Assessments; The purpose of this change is to update new entity names in conjunction with the Department merger. This amendment, therefore, updates Department and Division names with the establishment of the Department of Health and Human Services and the Division of Integrated Healthcare. It also makes other technical changes.	**5-1-23**	**6-7-23**
R414-9 Federally Qualified Health Centers; The purpose of this change is to implement by rule Medicaid policy for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to add services, and be reimbursed for added services that meet criteria as set forth in the rule. This amendment implements payment choices, prospective payments, and an alternate payment method for FQHCs. It further implements payment provisions for RHCs and details procedures for FQHC and RHC scope of service changes.	**5-1-23**	**6-7-23**
R414-32 Hospital Record-keeping Policy; The purpose of this change is to make clarifications and to reformat the text to be in accordance with standards set forth in the rule writing manual. This amendment renumbers the text, restructures sections, and restructures sentences for better clarity. It also updates Medicaid terms and specifies provider roles in terms of hospital recordkeeping policy.	**5-15-23**	**6-21-23**
R414-14 Home Health Services; The purpose of this change is to implement liability requirements for home health agencies in accordance with state law. This amendment includes new provisions of liability coverage for home health agency services. It also makes other technical changes.	**5-15-23**	**6-21-23**
R414-504 Nursing Facility Payments; The purpose of this change is to require nursing facilities to submit to the Department an optional state assessment (OSA) report for residents, to remove the sole community provider program, to remove the urban and non-urban cost differential which did not have any impact on rate-setting outcomes, and to make other technical changes. This amendment, therefore, requires nursing facilities to submit to the Department an OSA report, to ensure the Department receives data pertaining to resource utilization groups to calculate upper payment limit (UPL) payments. It also removes the sole community provider program, removes the urban and non-urban cost differential, updates entity names with the department merger and makes other technical changes.	**5-15-23**	**7-1-23**
R414-311 Targeted Adult Medicaid (Five-Year Review); The Department will continue this rule because it establishes eligibility provisions and requirements for the Targeted Adult Medicaid program.	**6-1-23**	**5-4-23**

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 June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-517**	**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:

Inpatient Hospital Provider Assessments

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 new entity names in conjunction with the Department merger.

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)**:**

This amendment updates Department and Division names with the establishment of the Department of Health and Human Services and the Division of Integrated Healthcare. It also makes other technical changes.

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 name and technical updates.

B) Local governments:

There is no impact on local governments as they neither fund nor provide services 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 name 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 name 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 name 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 name and technical updates.

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 there are only name and technical updates to the rule.

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	Title 26B, Chapter 3, Inpatient Hospital Assessment Act

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)	
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:	05/31/2023

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:	06/07/2023

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, 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:**	04/10/2023

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-517. Inpatient Hospital Provider Assessments.
R414-517-1. Introduction and Authority.

This rule defines the scope of hospital provider assessment. This rule is authorized under Title 26B, Chapter 3[~~6b~~], Inpatient Hospital Assessment Act.

R414-517-2. Definitions.

The definitions in Section 26B-3[~~6b~~]-[~~103~~]501 apply to this rule.

R414-517-3. Audit of Hospitals.

(1) For a hospital that does not file a Medicare cost report for the time frames outlined in Section 26B-3[~~6b~~]-[~~205~~]507, the Division of [~~Medicaid and Health Financing~~]Integrated Healthcare ([~~DMHF~~]DIH) shall audit the hospital's records to determine the correct discharges for the assessment.

(2) A hospital subject to the assessment shall make its records available for reasonable inspection upon written request from [~~DMHF~~]DIH. [~~DMHF~~]DIH shall consider a hospital that fails to make its records available to be non-compliant, and subject to the penalties set forth in Section R414-517-6.

R414-517-4. Change in Hospital Status.

(1)(a) If a hospital's status changes during any given year and it no longer falls under the definition of a hospital that is subject to the assessment outlined in Section 26B-3[~~6b~~]-[~~205~~]507, the hospital must submit in writing to [~~the Division of Medicaid and Health Financing~~][(~~DMHF~~)]DIH a notice of the status change and the effective date of that change. The notice must be mailed to the correct address, as follows, and is only effective upon receipt by the Reimbursement Unit:

Via United States Postal Service:
Utah Department of Health and Human Services
[~~DMHF~~]DIH, [~~BCRP~~]OFS
Attn: Reimbursement Unit
P.O. Box 143102
Salt Lake City, UT 84114-3102
Via United Parcel Service, Federal Express, and similar:
Utah Department of Health and Human Services
[~~DMHF~~]DIH, [~~BCRP~~]OFS
Attn: Reimbursement Unit
288 North 1460 West
Salt Lake City, UT 84116-3231

(b) DIH[~~MHF~~] may identify a hospital that has changed status and will not include that hospital in the subsequent quarterly assessment.

(2) The following provisions apply for any period in which a hospital is no longer subject to the assessment and notice has been given under Subsection [~~R414-517-4~~](1)(a), or when the hospital is identified by DIH[~~MHF~~] under Subsection [~~R414-517-4~~](1)(b):

(a) DIH[~~MHF~~] shall require payment of the assessment from that hospital for the full quarter in which the status change occurred and the hospital will receive full payment, as outlined in Section 26B-3[~~6b~~]-[~~2~~]51[~~0~~]1, for the applicable quarter; and

(b) the hospital is exempt from future assessment and not eligible for payment under this rule.

(3) For state fiscal year 2020 and subsequent years, before the beginning of each state fiscal year, DIH[~~MHF~~] shall determine whether a new provider is subject to the assessment. DIH[~~MHF~~] will add a newly identified provider prospectively, beginning that new state fiscal year. For example, a May 2019 evaluation that identifies a new provider will result in that new provider being added July 2019.

R414-517-5. Intergovernmental Transfer Calculation and Schedule.

DIH[~~MHF~~]shall calculate at a uniform rate for each hospital discharge, the non-state government hospital-intergovernmental transfer, as specified in Title 26B, Chapter 3[~~6b~~], Inpatient Hospital Assessment Act. DIH[~~MHF~~] shall determine the uniform rate by using the total number of hospital discharges for non-state government hospitals, and shall apply uniformly any quarterly changes to the uniform rate to all non-state government hospitals.

R414-517-6. Penalties and Interest.

(1) If DIH[~~MHF~~] audits a hospital's records to determine the correct discharges for the assessment for a hospital required to file a Medicare cost report, but the hospital fails to provide its Medicare cost report within the timeline required, DIH[~~MHF~~] shall fine the hospital 5% of its annual calculated assessment. The fine is payable within 30 days of invoice.

(2) If DIH[~~MHF~~] audits a hospital's records to determine the correct discharges for the assessment because the hospital does not file a Medicare cost report and did not submit its discharges and supporting documentation within the timeline required, DIH[~~MHF~~] shall fine the hospital 5% of its annual calculated assessment. The fine is payable within 30 days of invoice.

(3) If a hospital fails to fully pay its assessment on or before the due date, DIH[~~MHF~~] shall fine the hospital 5% of its quarterly calculated assessment. The fine is payable within 30 days of invoice.

(4) On the last day of each quarter, if a hospital has any unpaid assessment or penalty, DIH[~~MHF~~] shall fine the hospital 5% of the unpaid amount. The fine is payable within 30 days of invoice.

(5)(a) If a hospital fails to pay its assessment on or before the due date, DIH[~~MHF~~] shall suspend payments to the hospital until the assessment and any fines or penalties are paid in full.

(b) DIH[~~MHF~~] shall provide written notice before withholding payments.

(c) When DIH[~~MHF~~] rescinds withholding of payments to a provider, it will, without notice, resume payments according to the regular claims payment cycle.

R414-517-7. Rule Repeal.

The Department shall repeal this rule in conjunction with the repeal of the Inpatient Hospital Assessment Act outlined in Section 26B-3[~~6b~~]-[~~211~~]512.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: July 1, 2020
Authorizing, and Implemented or Interpreted Law: 26B-1-[~~5~~]213; 26B-[~~18~~]3-[~~3~~]108; 26B-3[~~6b~~]

State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-9**	**Filing ID: 55340**

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 agency.		

General Information

2. Rule or section catchline:

Federally Qualified Health Centers

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 implement by rule Medicaid policy for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to add services, and be reimbursed for added services that meet criteria as set forth in the rule.

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)**:**

This amendment implements payment choices, prospective payments, and an alternate payment method for FQHCs. It further implements payment provisions for RHCs and details procedures for FQHC and RHC scope of service changes.

Fiscal Information

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

A) State budget:

There is a potential impact to the state budget, but the Department cannot predict an impact because it does not know what services the providers, if any, will choose to add.

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 a potential impact on small businesses, but the Department cannot predict an impact because it does not know what services the providers, if any, will choose to add.

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

There is a potential impact on non-small businesses, but the Department cannot predict an impact because it does not know what services the providers, if any, will choose to add.

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 a potential impact to Medicaid providers, but the Department cannot predict an impact because it does not know what services the providers, if any, will choose to add.

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

There are potential costs to a single provider, but the Department cannot predict these costs because it does not know what services the provider, if any, will choose to add.

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 may see a change in revenue, but that change is unknown at this time.

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:	05/31/2023

9. This rule change MAY become effective on:	06/07/2023

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, 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:**	04/14/2023

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.

[~~Federally qualified health centers and rural health clinics provide a scope of services for Medicaid recipients in accordance with the Rural Health Clinics and Federally Qualified Health Centers Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.~~](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: July 11, 2014
Notice of Continuation: July 27, 2018
Authorizing, and Implemented or Interpreted Law: 26B-1-[~~5~~]213; [~~26-18-3~~]26B-3-108

State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-32**	**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:		
Contact persons:		
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 or section catchline:

Hospital Record-keeping Policy

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 make clarifications and to reformat the text to be in accordance with standards set forth in the rulewriting manual.

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)**:**

This amendment renumbers the text, restructures sections, and restructures sentences for better clarity. It also updates Medicaid terms and specifies provider roles in terms of hospital recordkeeping policy.

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 amendment simply clarifies the rule text and ongoing policy.

B) Local governments:

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

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

There is no impact to small businesses as this amendment simply clarifies the rule text and ongoing policy.

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

There is no impact to non-small businesses as this amendment simply clarifies the rule text and ongoing policy.

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 as this amendment simply clarifies the rule text and ongoing policy.

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 amendment simply clarifies the rule text and ongoing policy.

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 regulatory impact analysis. Neither businesses, governments, nor other entities will see a fiscal impact as this amendment simply clarifies the rule text and ongoing policy.

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	

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)	
Publisher	
Issue Date	
Issue or Version	

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:	06/14/2023

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:	06/21/2023
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, 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	**Date:**	03/27/2023

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-32. Hospital Record-keeping Policy.
R414-32-1. Introduction.

[~~1. General Requirement~~]

A hospital [~~providing~~]that provides care for a[~~ny Utah~~] Medicaid [~~patient~~]member must provide sufficient documentary evidence that ancillary services for which Medicaid is billed [~~were actually~~]are [~~rendered~~]provided in the diagnosis [~~and/~~]or treatment of [~~that~~]the [~~patient~~]member and that [~~such~~]services [~~were~~]are [~~properly~~]authorized by a licensed [~~physician~~]provider. Medicaid may not provide reimbursement [~~I~~]if [~~such~~]a hospital does not provide evidence [~~is not provided~~]in accordance with [~~the provisions of~~]this [~~administrative~~]rule[~~, then reimbursement for such unsupported charges will not be allowed by Medicaid.~~

[~~2. Documentation That Services Were Rendered~~]

R414-32-2. Documentation Requirements.

Sufficient documentary evidence [~~that an ancillary service was rendered~~]consists of medical reports, x-rays, and laboratory analyses.[~~normally provided by the department which renders the service. Department l~~] Logs may be accepted as documentation [~~that ancillary services were rendered~~]if each entry is signed and dated by an [~~authorized~~]individual authorized to provide[~~rendering the~~] services.

[~~3. Documentation That Services Were Properly Authorized~~]

R414-32-3. Documentation of Authorized Services.

(1) Sufficient documentary evidence [~~of a physician authorization~~]of authorized services consists of a written order signed and dated by a licensed [~~physician~~]provider within the time limits specified in the bylaws of the hospital or within [~~thirty (30)~~]30 days after the date of discharge, whichever is sooner.

(2) A written departmental protocol is acceptable as authorization if the protocol is specific [~~with respect~~]to both [~~to~~]the medical service [~~to be rendered~~]and to the conditions and circumstances under which the service may be given without the direct authorization of a licensed [~~physician~~]provider. [~~All such p~~]Protocols must have the [~~formal~~]written approval of the appropriate medical staff committees [~~of the hospital~~]and be signed by the [~~physician~~]licensed provider in charge of the care unit.

[~~4. Notification of Discrepancies~~]

R414-32-4. Discrepancies Between Services and Charges.

(1) [~~If, upon examination of a hospital patient's medical record 30 days or more after the patient was discharged,~~]If there is no [~~sufficient~~]documentary evidence [~~is not found~~]to support charges for ancillary services, the Department [~~of Health or its agent will~~]shall notify the hospital in writing of [~~such~~]the discrepancy.

(2) If the hospital, within 30 days of notification,[~~within thirty (30) days of the date the hospital is notified of such discrepancy, the hospital compiles in the medical record sufficient~~] compiles and submits documentary evidence [~~in~~]to support [~~of~~]the charges, [~~that was noted as a discrepancy,~~]then [~~such~~]the Department shall consider the evidence [~~will be considered~~]sufficient to provide payment.

(3) If the hospital does not place [~~such~~]the evidence in the medical record and submit that evidence to Medicaid within [~~thirty (~~]30[~~)~~] days after [~~being notified of the discrepancy~~]notification, [~~then~~]the Department will not reimburse the hospital nor accept subsequent documentation for the unsupported charges.[~~reimbursement will not be allowed for the unsupported item. Subsequent presentation of any documentation will not be accepted by the Department of Health.~~]

KEY: [~~m~~]Medicaid
Date of Last Change: 1987
Notice of Continuation: October 12, 2022
Authorizing, and Implemented or Interpreted Law: [~~26-1-5~~]26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-14**	**Filing ID: 55386**

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 agency.		

General Information

2. Rule or section catchline:

Home Health Services

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 implement liability requirements for home health agencies in accordance with Section 26B-3-116.

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)**:**

This amendment includes new provisions of liability coverage for home health agency services. It also makes other technical changes.

Fiscal Information

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

A) State budget:

The Department will see neither costs nor revenue as there is no direct impact on payments and services.

B) Local governments:

Local governments will see neither costs nor revenue as they neither fund nor provide home health services under the Medicaid program.

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

Small businesses will see neither costs nor revenue as there is no direct impact on payments and services.

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

Non-small businesses will see neither costs nor revenue as there is no direct impact on payments and services.

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***)**:**

Other persons or entities will see neither costs nor revenue as there is no direct impact on payments and services.

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 there is no direct impact on payments and services.

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 does not directly affect payments and services.			

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:	06/14/2023

9. This rule change MAY become effective on:	06/21/2023
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, 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:**	05/01/2023

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-14. Home Health Services.
R414-14-1. Introduction and Authority.

(1) Home health services are part-time intermittent health care services [~~that are~~]based on medical necessity and provided to eligible persons in their places of residence when the home is the most appropriate and cost-effective setting [~~that is~~]consistent with the [~~client's~~]member's medical need. The goals of home health care are to minimize the effects of disability or pain[~~,~~], [~~promote,~~]maintain[~~,~~] or protect health[~~,~~], and prevent premature or inappropriate institutionalization.

(2) This rule is authorized under Section 26B-[~~18~~]3-[~~3~~]108 and governs the services allowed under 42 CFR 440.70 and 42 CFR, Part 484. 42 U.S.C. Secs. 1395u, 1395x, and 1395y also authorize home health services.

R414-14-2. Definitions.

[~~The following definition applies to home health services. In addition, the Department adopts the definitions in the Home Health Agencies Utah Medicaid Provider Manual and incorporates them by reference in Section R414-1-5.~~]

(1) "Plan of [~~C~~]care" means a written plan developed cooperatively by home health agency staff and [~~the~~]an attending physician. The plan is designed to meet specific needs of an individual, is based on orders written by [~~the~~]an attending physician, and is approved and periodically reviewed and updated by [~~the~~]an attending physician.

(2) "Home health services" as defined in 42 CFR 440.70(b).

(3) "Home health agency visit" means a personal contact in the member's place of residence to provide a covered service.

(4) "Home health agency" means a public agency or private organization licensed to provide home health services.

(5) "Home health aide" means an individual who meets state and federal requirements of a home health aide, including those outlined in this rule, Rule R432-725, 42 CFR 440.70 and 484.80, and Sections R432-700-22 through R432-700-23.

(6) "Home health assessment visit" means a visit by a registered nurse initially or at recertification to assess the member's overall condition to determine the adaptability of the member's place of residence for the provision of health care and the capability of the member to participate in self-care. The visit also identifies family support systems or individuals willing to assume responsibility for care when the member cannot.

(7) "Skilled nursing" means services used in the treatment of an acute illness, injury, or exacerbation of a chronic illness.

(8) "Supervision" means authoritative procedural guidance by a qualified healthcare professional for the accomplishment of a function or activity.

(9) "Supportive maintenance home health" means a level of hands-on service that requires minimal assistance, observation, teaching, or follow-up essential to health care.

R414-14-3. [~~Client~~]Member Eligibility Requirements.

Home health services are available to categorically eligible and medically needy individuals.

R414-14-4. Program Access Requirements.

(1) A home health agency may only provide [~~H~~]home health services [~~shall be provided only~~]to an individual who is under the care of a physician. [~~The~~]An attending physician shall write the orders on which a plan of care is established and certify the necessity for home health services.

(2) [~~The~~]A home health agency may only accept a [~~recipient~~]member for home health services [~~only~~]if there is a reasonable expectation the agency can meet[~~that a recipient's~~] the member's needs[~~ can be met~~].

(3) The attending physician and home health agency personnel must review and sign a total plan of care as often as the severity of the [~~patient's~~]member's condition requires, but at least once every 60 days in accordance with 42 CFR 440.70.

(4) The home health agency must provide quality, cost-effective care and a safe environment in the home through registered or licensed practical nurses who have adequate training, knowledge, judg[~~e~~]ment, and skill.

(5) The home health agency may only provide [~~H~~]home health aide services [~~may only be provided~~]pursuant to written instructions and under the supervision of a registered nurse by a person selected and trained to assist with routine care not requiring specialized nursing skills.

(6) Over the long~~-~~term service period, the cost to provide the required service in the [~~patient's~~]member's home must be no greater than the cost to meet the [~~client's~~]member's medical needs in an alternative setting.

(7) A home health agency may provide an initial assessment visit without prior authorization to assess the [~~patient's~~]member's needs and establish a plan of care. After the initial visit, [~~all~~]home health care and service must be based on prior authorization.

(8) The home health agency must meet the face-to-face requirement, as stated in Section R414-1-30, or the Department may deny or recover reimbursement.

R414-14-5. Service Coverage.

(1) The Department covers the following [~~T~~]two levels of home health services[~~ are covered~~]:

(a) [~~S~~]skilled [~~H~~]home [~~H~~]health [~~S~~]services; and

(b) [~~S~~]supportive [~~M~~]maintenance [~~H~~]home [~~H~~]health [~~S~~]services.

(2) Skilled nursing services encompass[~~es~~] the expert application of nursing theory, practice and techniques by a registered professional nurse to meet the needs of [~~patients~~]members in their place of residence through professional judgments, through independently solving [~~patient~~]member care problems, and through application of standardized procedures and medically delegated techniques.

(3) Home health aide service encompasses assistance with, or direct provision of, routine care not requiring specialized nursing skill. The home health aide is closely supervised by a registered, professional nurse to assure competent care. The aide works under written instructions and provides necessary care for the [~~patient~~]member.

(4) Supportive maintenance home health care serves [~~those patients who have~~]members with a stabilized medical condition[~~ which has stabilized, but~~] who continue to demonstrate [~~continuing~~]health problems [~~requiring~~]that require minimal assistance, observation, teaching, or follow-up. A certified home health agency may provide [~~T~~]this assistance [~~can be provided by a certified home health agency~~]through the knowledge and skill of a licensed practical nurse (LPN) or a home health aide with periodic supervision by a registered nurse. A physician continues to provide direction.

(5) Home health agencies provide IV therapy, enteral and parenteral nutrition therapy [~~are provided as a home health service~~]either in conjunction with skilled or maintenance care or as the only service to be provided. Specific policy is outlined in the Medical Supplies and Durable Medical Equipment Utah Medicaid Provider Manual, and [~~all~~]requirements of the home health program must be met in relation to orders, plan of care, and 60-day review and recertification.

(6) Physical therapy and speech-language pathology services are occasionally indicated and approved for [~~the patient~~]a member [~~needing~~]who needs home health services. Any therapy services offered by the home health agency directly or under arrangement must be ordered by a physician and provided by a qualified licensed therapist in accordance with the plan of care. Occupational therapy and speech-language pathology services in the home are available only to [~~clients~~]members who are pregnant women or who are eligible under the Early and Periodic Screening, Diagnos[~~is~~]tic and Treatment Program (EPSDT).

(7) Medical supplies utilized for home health service must be consistent with physician orders, and approved as part of the plan of care.

(8) Medical supplies provided by the home health agency do not require prior approval, but are limited to:

(a) supplies used during the initial visit to establish the plan of care;

(b) supplies that are consistent with the plan of care; and

(c) non-durable medical equipment.

(9) Supportive maintenance home health services [~~is~~]are limited in time equal to one visit [~~per~~]a day determined by care needs and care[ ]giver participation.

(10) A registered nurse employed by an approved, certified home health agency must supervise [~~all~~]home health services. An appropriate licensed professional must provide [~~N~~]nursing [~~service~~]and [~~all~~]approved therapy services[~~ must be provided by the appropriate licensed professional~~].

(11) Only one home health provider [~~(agency)~~]may provide service to a [~~patient~~]member during any period[~~ of time~~]. [~~However, a~~]A subcontractor of a home health provider, however, may provide services if the original agency is the only provider that bills for services. The Department shall deny [~~A~~]a second provider or agency [~~requesting~~]that requests approval of services[~~ will be denied~~].

(12) Medicaid does not cover [~~H~~]home health care provided to a [~~patient~~]member capable of self-care[~~ is not a covered Medicaid benefit~~].

(13) Medicaid does not cover [~~P~~]personal care services, except as determined necessary in providing skilled care[~~, is not a covered home health benefit~~].

(14) Medicaid does not cover [~~H~~]housekeeping or homemaking services[~~ are not covered home health benefits~~].

(15) Medicaid does not cover [~~O~~]occupational therapy[~~ is not a covered Medicaid benefit~~] except for children covered under the Child Health Evaluation and Care Program (CHEC) for medically necessary services.

(16) Home health nursing services beyond the initial evaluation visit require[~~s~~] prior authorization.

(17) [~~All h~~]Home health services beyond the initial visit, including supplies and therapies, [~~shall~~]must be in the plan of care that the home health agency submits for prior authorization. After initial authorization, if level of service needs change and additional services are required, the home health agency must submit a new prior authorization request.

(18) A home health agency may provide therapy services only in accordance with medical necessity and after receiving prior authorization.

R414-14-6. Reimbursement for Services.

(1) Pursuant to Section 26B-3-116, the Department may not reimburse a home health agency, as defined by Section 26B-2-201, for home health services unless the agency has liability coverage of at least $500,000 for each incident.

(2) Home health agencies shall provide proof of liability coverage compliant with Subsection (1) within 30 days of request by the Department.

(3) In addition to other remedies allowed by law, the Department may withhold payment and end a provider agreement if a home health agency does not provide proof of liability coverage compliant with Subsection (1).

(4) The Department shall [~~R~~]reimburse[~~ment~~] for home health services [~~shall be provided as documented~~]in accordance with Attachment 4.19-B of the Medicaid State Plan.

KEY: Medicaid
Date of Last Change: July 1, 2017
Notice of Continuation: November 7, 2018
Authorizing, and Implemented or Interpreted Law: [~~26-1-5~~]26B-1-213; 26B-[~~18~~]3-[~~3~~]108

State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-504**	**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:

Nursing Facility Payments

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 require nursing facilities to submit to the Department an optional state assessment (OSA) report for residents, to remove the sole community provider program, to remove the urban and non-urban cost differential which did not have any impact on rate-setting outcomes, and to make other technical changes.

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)**:**

This amendment requires nursing facilities to submit to the Department an OSA report, to ensure the Department receives data pertaining to resource utilization groups to calculate upper payment limit (UPL) payments. It also removes the sole community provider program, removes the urban and non-urban cost differential, updates entity names with the department merger and makes other technical changes.

Fiscal Information

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

A) State budget:

There may be some administrative costs associated with submitting OSA data; however, there is no data to estimate what those costs might be.

B) Local governments:

There may be some administrative costs associated with submitting OSA data; however, there is no data to estimate what those costs might be.

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

There may be some administrative costs associated with submitting OSA data; however, there is no data to estimate what those costs might be.

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

There may be some administrative costs associated with submitting OSA data; however, there is no data to estimate what those costs might be.

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 may be some administrative costs associated with submitting OSA data; however, there is no data to estimate what those costs might be.

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

There may be some administrative costs associated with submitting OSA data; however, there is no data to estimate what those costs might be.

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 S. Gruber, has reviewed and approved this fiscal analysis. Businesses may see administrative costs, but there is no data to estimate what those costs might be.

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	

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)	
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:	06/14/2023

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:	06/21/2023

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, 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:	05/01/2023

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-504. Nursing Facility Payments.
R414-504-1. Introduction.

(1) This rule adopts a case mix or severity-based payment system[~~, commonly referred to as RUGS (Resource Utilization Group System)~~] for nursing facilities that are not [~~ICF/MRs~~]intermediate care facilities for persons with intellectual disabilities (ICF/IDs). This system reimburses facilities based on the case mix index of the facility. It also establishes rates for ICF/[~~MR~~]ID facilities.

(2) This rule is authorized by [~~Utah Code s~~]Sections 26B-1-[~~5~~]213, 26B-[~~18~~]3-[~~3~~]108, and Title 26B, Chapter 3[~~-35a~~].

R414-504-2. Definitions.

The definitions in Sections R414-1-2 and R414-501-2 apply to this rule. In addition:

(1) "Behaviorally complex resident" means a long-term care resident with a severe, medically based behavior disorder, including traumatic brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgment, retention of information or decision-making skills, or a resident, who meets the Medicaid criteria for nursing facility level of care and who has a medically based mental health disorder or diagnosis and has a high level resource use in the nursing facility not currently recognized in the case mix.

(2) "Case mix index" means a score assigned to each facility based on the average of the Medicaid patients' [~~RUGS~~]case mix scores for that facility.

(3) "Case mix score" means the acuity or frailty of a resident based on medical needs resulting in a weight used to calculate rates.

([~~3~~]4) "Facility case mix rate" means the rate the Department issues to a facility for a specified period[~~-of time~~]. This rate utilizes the case mix index for a provider, labor wage index application, and other case mix-related costs.

([~~4~~]5) "FCP" means the facility cost profile report filed by the provider on an annual basis.

([~~5~~]6) "Minimum [~~D~~]data [~~S~~]set" (MDS) means a set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for residents of long-term care facilities certified to participate in Medicaid.

([~~6~~]7) "Nursing [~~C~~]costs" means the current costs from the annual FCP report reported on lines 070-012 Nursing Admin Salaries and Wages, 070-013 Nursing Admin Tax and Benefits, 070-040 Nursing Direct Care Salaries and Wages, 070-041 Nursing Direct Care Tax and Benefits, and 070-050 Purchased Nursing Services.

([~~7~~]8) "Nursing facility" or "facility" means a Medicaid-participating nursing facility, skilled nursing facility, or a combination thereof, as defined in 42 USC 1396r (a), 42 CFR 440.150, 42 CFR 442.12, and S[~~ubs~~]ection 26B-2[~~1~~]-201[~~(15)~~].

([~~8~~]9) "Patient day" means the care of one patient during a day of service, excluding the day of discharge.

([~~9~~]10) "Patient-driven payment model" (PDPM) means the Medicare prospective payment system for classifying skilled nursing facility patients in a covered Medicare Part A stay.

(1[~~0~~]1) "Property costs" means the fair rental value (FRV) established by this rule.

[~~(11) "RUGS" means the 34 RUG identification system based on the resource utilization group system established by Medicare to measure and ultimately pay for the labor, fixed costs, and other resources necessary to provide care to Medicaid patients. Each RUG is assigned a weight based on an assessment of its relative value as measured by resource utilization.~~

~~(12) "RUGS score" means a total number based on the individual RUGS derived from a resident's physical, mental, and clinical condition, which projects the amount of relative resources needed to provide care to the resident. RUGS is calculated from the information obtained through the submission of the MDS data.~~

~~(13) "Sole community provider" means a facility that is not an urban provider and is not within 30 paved road miles of another existing facility and is the only facility:~~

~~(a) within a city, if the facility is located within the incorporated boundaries of a city; or~~

~~(b) within the unincorporated area of the county if it is located in an unincorporated area.~~

~~(14)(a) "Urban provider" means a facility located in a county that has a population greater than 90,000 persons.~~

~~(b) "Rural provider" means a facility that is not an urban provider.~~]

(1[~~5~~]2) "[~~FRV~~]Fair rental value (FRV) [~~D~~]data [~~R~~]report" means a report that provides the Department with information relat[~~ing~~]ed to capital improvements to be included in the FRV calculation.

[~~(16) "Banked beds" means beds that have been taken offline by the provider, through the process defined by the Department of Health, Bureau of Health Facility Licensing, Certification and Resident Assessment, to reduce the operational capacity of the facility, but does not reduce the licensed bed capacity.~~]

(1[~~7~~]3) "Bed addition" means, as used in the fair rental value calculation, a capitalized project that adds additional beds to the facility. This must be new and complete construction. An increase in total licensed beds and new construction costs support a claim of additional beds.

(1[~~8~~]4) "Bed replacement" means, as used in the fair rental value calculation, a capitalized project that furnishes a bed in the place of another, previously existing bed. Room remodeling is not a replacement of beds. This must be new and complete construction.

(1[~~9~~]5) "Major [~~R~~]renovation" means, as used in the fair rental value calculation, a capitalized project with a cost equal to or

greater than $500 [~~per~~]for a licensed bed. A renovation extends the life, increases the productivity, or significantly improves the safety, such as by asbestos removal, of a facility as opposed to repairs and maintenance that either restore the facility to, or maintain it at its normal or expected service life. Vehicle costs are not a major renovation capital expenditure.

R414-504-3. Principles of Facility Case Mix Rates and Other Payments.

The following principles apply to the payment of freestanding and provider-based nursing facilities for services [~~rendered~~]provided to qualified Medicaid patients, as defined in Rule R414-502. This rule does not affect the system for reimbursement for intensive-skilled Medicaid patient add-on amounts.

(1) A portion of total payments to nursing facilities for qualified Medicaid patients is based on a prospective facility case mix rate. In addition, these facilities shall be paid a flat basic operating expense payment. The balance of the total payments will be paid in aggregate to facilities as required by Section R414-504-3 based on other authorized factors, including property and behaviorally complex residents, in the proportion that the facility qualifies for the factor.

(2) Each quarter, the Department shall calculate a new case mix index for each nursing facility. The case mix index is based on three months of MDS assessment data. The newly calculated case mix index is applied to a new rate at the beginning of a quarter according to the following schedule:

(a) January, February, and March MDS assessments are used for July 1 rates.

(b) April, May, and June MDS assessments are used for October 1 rates.

(c) July, August, and September MDS assessments are used for January 1 rates.

(d) October, November, and December MDS assessments are used for April 1 rates.

(3) MDS and optional state assessment (OSA) data is used in calculating each facility's case mix index and upper payment limit (UPL) gap. Beginning July 1, 2023, each facility must complete an OSA in conjunction with any Omnibus Budget Reconciliation Act or prospective payment system assessments. This information is required by the state to calculate the case mix index. The MDS and OSA data is submitted by each facility and[~~, as such,~~] each facility is responsible for the accuracy of its data. Each facility shall ensure needed sections of the MDS and OSA are completed so that a PDPM or resource utilization group score may be calculated. The Department may exclude inaccurate or incomplete MDS data from calculations.

(4)(a) MDS assessments for patients who are eligible for the intensive skilled add-on are excluded from the case mix calculation.

(b) The state average case mix index excludes the following:

(i) a facility with less than 20% of its total census days as Medicaid fee-for-service paid days, as reported on its FCP or FRV data report; or

(ii) a facility having less than six months of data reported under Rule R414-401.

(c) The state average case mix index is used to set the rate for the following facilities:

(i) a facility with less than 20% of its total census days as Medicaid fee-for-service paid days, as reported on its FCP or FRV data report; or

(ii) a facility having less than six months of data reported under Rule R414-401.

(5) A facility may apply for a special add-on rate for behaviorally complex residents by filing a written request with the Division of [~~Medicaid and Health Financing~~]Integrated Healthcare (DIH). The Department may approve an add-on rate if an assessment of the acuity and needs of the patient demonstrates that the facility is not adequately reimbursed by the [~~RUGS~~]case mix score for that patient. The rate is added on for the specific resident's payment and is not subsumed as part of the facility case mix rate. [~~Utah's~~]The [~~Bureau~~]Office of Long-Term Services and Supports [~~will make the determination as to~~]determines qualification for any additional payment. [~~The Division of Medicaid and Health Financing~~]DIH shall determine the amount of any add-on.

(6) [~~Property costs are paid~~]The Department pays property costs separately from the [~~RUGS~~]case mix rate.

(7) Reimbursement for nursing home rates is in accordance with Attachment 4.19-D of the [~~Utah~~]Medicaid State Plan, which is incorporated by reference in Section R414-1-5.

[~~(8) A sole community provider that is financially distressed may apply for a payment adjustment above the case mix index established rate. The maximum increase will be 7.5% above the average of the most recent Medicaid daily rate for all Medicaid residents in all freestanding nursing facilities in the state. The maximum duration of this adjustment is for no more than a total of 12 months per facility in any five-year period.~~

~~(a) The application shall propose what the adjustment should be and include a financial review prepared by the facility documenting:~~

~~(i) the facility's income and expenses for the past 12 months; and~~

~~(ii) specific steps taken by the facility to reduce costs and increase occupancy.~~

~~(b) Financial support from the local municipality and county governing bodies for the continued operation of the facility in the community is a necessary prerequisite to an acceptable application. The Department, the facility, and the local governing bodies may negotiate the amount of the financial commitment from the governing bodies, but in no case may the local commitment be less than 50% of the state share required to fund the proposed adjustment. Any continuation of the adjustment beyond six months requires a local commitment of 100% of the state share for the rate increase above the base rate. The applicant shall submit letters of commitment from the applicable municipality or county, or both, committing to make an intergovernmental transfer for the amount of the local commitment. If the governmental agency receives donations in order to provide the financial contribution, it must document that the donations are bona fideas set forth in 42 CFR 433.54.~~

~~(c) The Department may conduct its own independent financial review of the facility before making a decision whether to approve a different payment rate.~~

~~(d) If the Department determines that the facility is in imminent peril of closing, it may make an interim rate adjustment for up to 90 days.~~

~~(e) The Department's determination shall be based on maintaining access to services and maintaining economy and efficiency in the Medicaid program.~~

~~(f) If the facility desires an adjustment for more than 90 days, it must demonstrate that:~~

~~(i) the facility has taken reasonable steps to reduce costs, increase revenue, and increase occupancy;~~

~~(ii) despite reasonable steps the facility is losing money and forecast to continue losing money; and~~

~~(iii) the amount of the approved adjustment will allow the facility to meet expenses and continue to support the needs of the community it serves, without unduly enriching any party.~~

~~(g) If the Department approves an interim or other adjustment, it shall notify the facility when the adjustment is scheduled to take effect and how much contribution is required from the local governing bodies. Payment of the adjustment is contingent on the facility obtaining a fully executed binding agreement with local governing bodies to pay the contribution to the Department.~~

~~(h) The Department may withhold or deny payment of the interim or other adjustment if the facility fails to obtain the required agreement before the scheduled effective date of the adjustment.~~]

([~~9~~]8) A provider may challenge the rate set pursuant to this rule using the appeal in Rule R410-14. This applies to which rate methodology is used as well as to the specifics of implementation of the methodology. A provider must exhaust administrative remedies before challenging rates in any other forum.

[~~(10) In developing payment rates, the Department may adjust urban and non-urban rates to reflect differences in urban and non-urban labor costs. The urban labor costs reimbursement cannot exceed 106% of the non-urban labor costs. Labor costs are as reported on the most recent FCP, but do not include FCP-reported management, consulting, director, and home office fees.~~]

([~~11~~]9) The Department reimburses swing beds, transitional care unit beds, and small health care facility beds that are used as nursing facility beds, using the prior calendar year statewide average of the daily nursing facility rate.

(1[~~2~~]0) Unless specified otherwise, the Department may withhold Title XIX payments from providers if:

(a) there is a shortage in a resident trust account managed by the facility;

(b) the facility fails to submit a complete and accurate FCP as required by Attachment 4.19-D[~~, Section 332~~] of the [~~Utah~~]Medicaid State Plan;

(c) the facility fails to submit timely, accurate MDS and OSA data;

(d) the facility owes money to [~~the Division of Medicaid and Health Financing~~]DIH because of an overpayment, nursing care facility assessment, civil money penalty, or other offset; or

(e) the facility fails to respond within [~~10~~]ten business days to a written request for information.

(1[~~3~~]1) The Department shall provide written notice before withholding payments.

(1[~~4~~]2) When the Department rescinds withholding of payments to a provider, it will, without notice, resume payments according to the regular claims payment cycle.

(a) For ongoing operations, the Department [~~will~~]shall provide notice before withholding payments. The Department and provider may negotiate a repayment schedule acceptable to the Department for monies owed to the Department listed in Subsection R414-504-3(10)[~~2)(a)(iv)~~]. The repayment schedule may not exceed 180 days.

(b) When the Department rescinds withholding of payments to a facility, it will resume payments according to the regular claims payment cycle.

R414-504-4. Quality Improvement Incentive.

(1) Reimbursement for Nursing Home Quality Improvement Incentives is in accordance with Attachment 4.19-D of the [~~Utah~~]Medicaid State Plan, which is incorporated by reference in Rule R414-1.

(2) [~~Division~~]DIH staff are not required to request additional information relating to any application submission.

(3) Providers shall ensure all necessary information is included in the application [~~in order~~]to qualify.

(4) For applications received and reviewed by [~~division~~]DIH staff [~~prior to~~]before the annual submission deadline, if the application is incorrect or lacks sufficient supporting documentation, then the application shall be denied. If it is received [~~prior to~~]before the annual submission deadline, the provider may submit a subsequent application that includes all needed supporting documentation for consideration.

(5) For applications received [~~prior to~~]before the annual submission deadline and reviewed by [~~division~~]DIH staff after the annual submission deadline, then the provider's application may be considered for qualification of a reduced amount, where possible, based on the submitted documentation.

(6) In all cases, [~~no~~]the Department does not accept additional applications, documentation, or explanation [~~will be accepted~~]if submitted after the annual submission deadline.

R414-504-5. Reimbursement for Intermediate Care Facilities for [~~the Mentally Retarded~~]Persons with Intellectual Disabilities.

The following principles apply to the payment of community-based [~~intermediate care facilities for the mentally retarded (ICF/MRs)~~]ICF/IDs [~~that are~~]licensed under Section [~~26-21-13.5:~~]26B-2-212.

(1) The Department pays according to rates [~~approximately 93% of the aggregate payments to ICF/MRs based on a prospective flat rate~~]established in [~~Utah State Plan~~]Attachment 4.19-D of the Medicaid State Plan.[~~The Department pays the balance as a property cost component calculated by the Fair Rental Value system pursuant to Section R414-504-3.~~]

(2)(a) Reimbursement for the [~~ICF/MR~~]ICF/ID [~~Q~~]quality [~~I~~]improvement [~~I~~]incentive is in accordance with Attachment

4.19-D of the [~~Utah~~]Medicaid State Plan, which is incorporated by reference in Rule R414-1.

(b) [~~Division~~]DIH staff are not required to request additional information relating to any application submission.

(c) Providers [~~shall~~]must ensure they include[~~all~~] necessary information [~~is included~~]in the application [~~in order~~]to qualify.

(d) For applications received and reviewed by [~~division~~]DIH staff [~~prior to~~]before the annual submission deadline, the Department shall deny them if they are incorrect or lack sufficient supporting documentation.[~~if the application is incorrect or lacks sufficient supporting documentation, then the application shall be denied.~~] If [~~it~~]the Department receives an application [~~is received prior to~~]before the annual submission deadline, the provider may submit a subsequent application that includes [~~all~~]needed supporting documentation for consideration.

(e) For applications received [~~prior to~~]before the annual submission deadline and reviewed by [~~division~~]DIH staff after the annual submission deadline, the Department may consider the provider's application[~~then the provider's application may be considered~~] for qualification of a reduced amount, where possible, based on the submitted documentation.

(f) [~~In all cases,~~]The Department does not accept[~~no~~] additional applications, documentation, or explanation[~~will be accepted~~] if submitted after the annual submission deadline.

KEY: Medicaid
Date of Last Change: October 1, 2020
Notice of Continuation: October 12, 2022
Authorizing, and Implemented or Interpreted Law: 26B-1-[~~5~~]213; 26B-3[~~5a~~]

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-311**	**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	
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City, state and zip:	Salt Lake City, UT 84114-3102	
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Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
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Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Targeted Adult Medicaid
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-1-213 grants the Department the power to adopt, amend, or rescind rules, and Section 26B-3-108 requires the Department to implement the Medicaid program through administrative 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 establishes eligibility provisions and requirements for the Targeted Adult Medicaid 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:	Tracy S. Gruber, Executive Director	**Date:**	05/04/2023
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, Health Care Financing, Coverage and Reimbursement Policy.
R414-311. Targeted Adult Medicaid.
R414-311-1. Introduction and Authority.

(1) This rule is authorized by Sections 26-1-5 and 26-18-3 and allowed under Subsection 1115(f) of the Social Security Act.

(2) This rule establishes eligibility requirements for enrollment under the 1115 Demonstration Waiver for Adults without Dependent Children, also known as the Targeted Adult Medicaid program.

R414-311-2. Definitions.

The definitions in Rules R414-1 and R414-301 apply to this rule. In addition, the following definitions apply throughout this rule:

(1) "Chronically homeless individual" means an individual who:

(a) has a substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic illness or disability; and

(i) lives or resides for at least 12 months, or on at least four separate occasions that amount to at least 12 months in the last three years, in a place not meant for human habitation, in a safe haven, or in an emergency shelter; or

(ii) lives in supportive housing and has previously met the criteria established in Subsection R414-311-2(1)(a)(i).

(b) lives or resides for at least six months within a 12-month period in a place not meant for human habitation, in a safe haven, or an emergency shelter, and has a substance use or serious mental health disorder; or

(c) is a victim of domestic violence who resides in a place not meant for human habitation, a safe haven, or in an emergency shelter.

(2) "Dependent child" means a child who is under 19 years of age, and required to be included in the household size for the Targeted Adult Medicaid program.

(3) "Individual needing treatment" means an individual who:

(a) receives General Assistance from the Department of Workforce Services and has been diagnosed with a substance use or mental health disorder; or

(b) was discharged from the Utah State Hospital and was admitted due to a civil commitment.

(4) "Justice involved individual" means an individual who needs substance use or mental health treatment and:

(a) has complied with and substantially completed a substance use disorder treatment program while incarcerated in jail or prison; or

(b) was discharged from the Utah State Hospital and was admitted to the civil unit in connection with a criminal charge, or to the forensic unit due to a criminal offense, in which the individual was charged or convicted;

(c) is involved with a drug or mental health court;

(d) is court-ordered to receive substance abuse or mental health treatment through a district or tribal court; or

(e) is on probation or parole with a serious mental illness, serious substance use disorder, or both.

R414-311-3. General Provisions.

(1) The provisions in Rule R414-301 apply to all applicants and enrollees, except that applicants and enrollees are required to report only the following changes in circumstances:

(a) The individual moves out of state; or

(b) The individual enters a public institution or an institution for mental disease.

R414-311-4. General Eligibility Requirements.

Unless otherwise stated, the provisions in Rule R414-302 and Section R414-306-4 apply to applicants and enrollees.

(1) The following individuals are not eligible for Targeted Adult Medicaid:

(a) Individuals who do not meet the coverage group criteria of being chronically homeless, justice-involved, or needing treatment as defined in Section R414-311-2;

(b) Individuals who have a dependent child under 19 years old;

(c) Individuals who are eligible for a Medicaid program without a spenddown; or

(d) Individuals who are eligible for or receive Medicare.

(2) An individual must be at least 19 years old and not yet 65 years old to enroll in Targeted Adult Medicaid.

(a) The month in which an individual turns 19 years old is the first month in which the individual may enroll in Targeted Adult Medicaid.

(b) An individual may only enroll in Targeted Adult Medicaid through the month in which the individual turns 65 years old.

(3) The eligibility agency only enrolls applicants during an open enrollment period. The eligibility agency may limit the number it enrolls and may stop enrollment at any time. The open enrollment period may be limited to a coverage group or a subgroup within the coverage group.

(4) The eligibility agency shall waive the open enrollment requirement for the following individuals:

(a) An individual who was previously on Targeted Adult Medicaid, and moves from another Medicaid program back to Targeted Adult Medicaid, is otherwise eligible, and there is no break in coverage between the medical programs;

(b) An enrollee who completes a review within three months of case closure as outlined in Section R414-308-6; or

(c) A member of a federally recognized tribe.

(5) The eligibility agency does not require a resource test.

R414-311-5. Application, Eligibility Reviews and Improper Medical Assistance.

(1) Unless otherwise stated, the provisions of Rule R414-308 apply to all applicants and enrollees.

(2) Subject to the provisions of Subsection R414-311-5(3), an individual who is determined eligible shall receive 12 months of coverage that begins with the first month of enrollment.

(3) Before the end of the 12-month certification period, the eligibility agency may terminate eligibility if the individual:

(a) turns 65 years old;

(b) moves out of state;

(c) becomes eligible for another Medicaid program;

(d) enters an institution for mental disease, except as described in Section R414-302-6;

(e) is convicted of fraud;

(f) leaves the household; or

(g) is eligible for or receives Medicare.

(4) An individual who leaves prison, jail, or the Utah State Hospital must submit an application within 60 days of release or discharge.

(5) An enrollee must verify at each review, that the enrollee meets the criteria of a coverage group, as defined in Section R414-311-2. An enrollee who no longer meets criteria of a coverage group is no longer eligible for Targeted Adult Medicaid.

R414-311-6. Household Composition and Income Provisions.

(1) The eligibility agency shall use the provisions of Section R414-304-5 to determine household composition and countable income.

(2) Section R414-304-12 applies to the budgeting of income through the Modified Adjusted Gross Income (MAGI) methodology.

(3) For an individual to be eligible to enroll in Targeted Adult Medicaid, the individual must have countable income at or below 5% of the federal poverty level (FPL).

R414-311-7. Public Health Emergency Provisions.

The Targeted Adult Medicaid Program is in accordance with emergency provisions set forth in Section R414-304-17 and Section R414-308-11.

KEY: Medicaid, Targeted Adult Medicaid, eligibility
Date of Enactment or Last Substantive Amendment: September 16, 2020
Authorizing, and Implemented or Interpreted Law: 26-18