# DIH Rules Matrix 11-21-24

| Rule Summary | Bulletin Publication | Effective |
|---|---|---|
| **R382-10 Eligibility (CHIP);** The purpose of this change is to update the rule following the conclusion of a public health emergency. This amendment, therefore, removes provisions for the coronavirus public health emergency that concluded in May 2023 and updates the rule to include minor changes in structure, formatting, and grammar to comply with the Rulewriting Manual for Utah. | **11-15-24** | **12-23-24** |
| **R414-40-3 Program Access Requirements;** The purpose of this change is to update and clarify current policy for provider requests of prior authorization for private duty nursing services, as a result of internal agency review. This amendment, therefore, removes the requirement for providers to submit initial prior authorization requests and removes the requirement for home health agencies to submit an initial certification and recertification at least every 60 days. Additionally, this amendment makes style and formatting changes to comply with the Rulewriting Manual for Utah. | **11-15-24** | **12-23-24** |
| **R414-1-32 Prior Authorization from Primary Payers First;** The purpose of this change is to encourage health care providers to seek prior authorization from a primary payer before seeking third party liability through Medicaid. This change also has the effect of prohibiting health insurance entities from denying a claim submitted by the Department of Health and Human Services or the department's contractor based solely on the lack of prior authorization. Both changes are in accordance with changes made to Subsection 26B-3-1004 as a result of HB501 from the 2024 General Session. | **11-15-24** | **12-23-24** |

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

**State of Utah**
**Administrative Rule Analysis**
Revised May 2024

| NOTICE OF SUBSTANTIVE CHANGE | | |
|---|---|---|
| **TYPE OF FILING:** Amendment | | |
| **Rule or Section Number:** | **R382-10** | **Filing ID: 56886** |

**Agency Information**

| | | |
|---|---|---|
| **1. Title catchline:** | Health and Human Services, Children's Health Insurance Program | |
| **Building:** | Cannon Health Building | |
| **Street address:** | 288 N. 1460 W. | |
| **City, state:** | Salt Lake City, UT | |
| **Mailing address:** | PO Box 1433325 | |
| **City, state and zip:** | Salt Lake City, UT 84114-3325 | |
| **Contact persons:** | | |
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| Craig Devashrayee | 801-538-6641 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |
| **Please address questions regarding information on this notice to the persons listed above.** | | |

**General Information**

**2. Rule or section catchline:**

R382-10. Eligibility.

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

The purpose of this change is to update the rule following the conclusion of a public health emergency.

**4. Summary of the new rule or change:**

This amendment removes provisions for the coronavirus public health emergency that concluded in May 2023 and updates the rule to include minor changes in structure, formatting, and grammar to comply with the Rulewriting Manual for Utah.

**Fiscal Information**

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

**A) State budget:**

This filing is anticipated to have no fiscal impact on the state budget, as there are no fiscal changes that accompany these policy updates and technical corrections. Additionally, these updates neither affect member services nor provider reimbursement.

**B) Local governments:**

This filing is anticipated to have no fiscal impact on local governments, as they neither fund nor provide services under the Children's Health Insurance Program.

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

This filing is anticipated to have no fiscal impact on small businesses, as there are no fiscal changes that accompany these policy updates and technical corrections. Additionally, these updates neither affect member services nor provider reimbursement.

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

This filing is anticipated to have no fiscal impact on non-small businesses, as there are no fiscal changes that accompany these policy updates and technical corrections. Additionally, these updates neither affect member services nor provider reimbursement.

**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***)**:**

This filing is anticipated to have no fiscal impact on other persons, as there are no fiscal changes that accompany these policy updates and technical corrections. Additionally, these updates neither affect member services nor provider reimbursement.

**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 anticipated compliance costs expected for affected persons, as there are no fiscal changes that accompany these policy updates and technical corrections. Additionally, these updates neither affect member services nor provider reimbursement.

**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** | **FY2025** | **FY2026** | **FY2027** |
|---|---|---|---|
| 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** | **FY2025** | **FY2026** | **FY2027** |
| 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.

**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-3-902 | |

**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:** | 12/16/2024 |

| | |
|---|---|
| **9. This rule change MAY become effective on:** | 12/23/2024 |

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

**Agency Authorization Information**

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

| | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Executive Director | **Date:** | 10/27/2024 |

**R382. Health and Human Services, Children's Health Insurance Program.**
**R382-10. Eligibility.**
**R382-10-1. Authority and Purpose.**

(1) This rule is authorized by Title 26B, Chapter 3, Part 9, Utah Children's Health Insurance Program.

(2) This rule sets forth eligibility requirements for coverage under the Children's Health Insurance Program (CHIP).

**R382-10-2. Definitions.**

[~~(1)~~ ]The definitions found in S[~~ubs~~]ections 2110(b) and (c) of the Compilation of Social Security Laws, and in Section R382-1-2 apply to this rule. Additionally, the following definitions apply:

[~~(2) In addition, the department adopts the following definitions:~~

~~(a)~~ (1) "American Indian or Alaska Native" means someone having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.

([~~b~~]2) "Best estimate" means the eligibility agency's determination of a household's income for the upcoming eligibility period, based on past and current circumstances and anticipated future changes.

([~~c~~]3) "COBRA" means health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

([~~d~~]4) "Copayment and coinsurance" means a portion of the cost for a medical service, in which the member is responsible to pay for services received under CHIP.

([~~e~~]5) "Due process month" means the month that allows time for the member to return verifications, and for the eligibility agency to determine eligibility and notify the member.

([~~f~~]6) "Eligibility agency" means the Department of Workforce Services (DWS) that determines eligibility for CHIP under contract with the department.

([~~g~~]7) "Employer-sponsored health plan" means a health insurance plan offered by an employer.

([~~h~~]8) "Ex parte review" means a review process the agency conducts without contacting the member for information as defined in 42 CFR 457.343[~~.~~] (2024).

([~~i~~]9) "Federally Facilitated Marketplace" (FFM) means the entity an individual can access to enroll in health insurance and apply for assistance from insurance affordability programs such as Advanced Premium Tax Credits, Medicaid, and CHIP.

([~~j~~]10) "Member" means any person who is enrolled in the [~~Medicaid~~]CHIP program and is eligible to receive [~~Medicaid~~]CHIP services.

([~~k~~]11) "Modified Adjusted Gross Income" (MAGI) means the income determined using the methodology defined in 42 CFR 435.603(e).

([~~l~~]12) "Presumptive eligibility" means a period that a child may receive CHIP benefits based on preliminary information that the child meets the eligibility criteria.

([~~m~~]13) "Review month" means the last month of the eligibility certification period for a member, in which the eligibility agency determines a member's eligibility for a new certification period.

([~~n~~]14) "Utah's Premium Partnership for Health Insurance" [~~or "~~](UPP[~~"~~]) means the program described in Rule R414-320.

**R382-10-3. Actions on Behalf of a Minor.**

(1) A parent, legal guardian, or an adult who assumes responsibility for the care or supervision of a child who is under 19 years of age may apply for CHIP enrollment, provide information required by this rule, or otherwise act on behalf of a child in [~~all~~]any respects under the statutes and rules governing the CHIP program.

(2) If the child's parent, responsible adult, or legal guardian wants to designate an authorized representative, [~~he~~]the parent must [~~so indicate~~]state it in writing to the eligibility agency.

(3)(a) A child who is under 19 years of age and is independent of a parent or legal guardian may assume these responsibilities. [-]The eligibility agency may not require a child who is independent to have an authorized representative if the child can act on [~~his~~]the child's own behalf[~~, however, the~~].

(b) The eligibility agency may designate an authorized representative if the child needs a representative but cannot make a choice either in writing or orally in the presence of a witness.

(4) Where the statutes or rules governing the CHIP program require a child to take an action, the parent, legal guardian, designated representative or adult who assumes responsibility for the care or supervision of the child is responsible to take the action on behalf of the child. If the parent or adult who assumes responsibility for the care or supervision of the child fails to take an action, the failure is attributable as the child's failure to take the action.

(5) The eligibility agency shall consider notice to the parent, legal guardian, designated representative, or adult who assumes responsibility for the care or supervision of a child to be notice to the child. The eligibility agency shall send notice to a child who assumes their own responsibility[~~ for himself~~].

**R382-10-4. Applicant and Enrollee Rights and Responsibilities.**

(1) A parent or an adult who assumes responsibility for the care or supervision of a child may apply or reapply for CHIP benefits on behalf of a child. A child who is independent may apply on the child's own behalf.

(2) If a person needs assistance to apply, the person may request assistance from a friend, family member, the eligibility agency, or outreach staff.

(3) The applicant must provide verification requested by the eligibility agency to establish the eligibility of the child, including information about the parents.

(4) Anyone may look at the eligibility policy manuals located online or at any eligibility agency office that is not an outreach or telephone-only location.

(5) If the eligibility agency determines that the child received CHIP coverage during a period when the child was not eligible for CHIP, the parent, child, or legal guardian who arranges for medical services on behalf of the child must repay the department for the cost of services.

(6) The parent or child, or other responsible person acting on behalf of a child, must report certain changes to the eligibility agency.

(a) The following changes are reportable within ten calendar days of the day of the change:

(i) the member begins to receive coverage or to have access to coverage under a group health plan or other health insurance coverage;

(ii) the member leaves the household or dies;

(iii) the member or the household moves out of state;

(iv) the member or the household changes address; and

(v) the member enters a public institution or an institution for mental disease.

(b) Certain changes are reportable as part of the review process if these changes occurred anytime during the certification period and before the 10-day notice due date in the review month. The member must report a change in the following as part of the review process for any household member:

(i) income source;

(ii) gross income of $25 or more;

(iii) tax filing status;

(iv) pregnancy or termination of a pregnancy;

(v) number of dependents claimed as tax dependents;

(vi) earnings of a child;

(vii) marital status; and

(viii) student status of a child under 24 years of age.

(7) An applicant and a member may review the information that the eligibility agency uses to determine eligibility.

(8) An applicant and a member have the right to be notified about actions that the agency takes to determine the applicant's or member's eligibility or continued eligibility, the right to be notified about the reason the action was taken, and the right to request an agency conference or agency action as defined in Sections R414-301-6 and[ ~~Section~~] R414-301-7.

(9) A CHIP member must pay copayments or coinsurance amounts to providers for medical services that the member receives under CHIP.

**R382-10-5. Verification and Information Exchange.**

(1) [~~The provisions of~~ ]Section R414-308-4 appl[~~y~~]ies to applicants and enrollees of CHIP.

(2) The [~~D~~]department and the eligibility agency shall safeguard applicant and enrollee information in accordance with Section R414-301-4.

(3) The [~~D~~]department or the eligibility agency may release information concerning applicants and enrollees and their households to other state and federal agencies to determine eligibility for other public assistance programs.

(4) The [~~Department adopts and incorporates by reference~~]department complies with 42 CFR 457.348, 457.350, and 457.380[~~, October 1, 2012 ed~~] in regard to eligibility determinations, screening, and verification.

(5) The [~~D~~]department shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to allow the FFM to screen applications and reviews submitted through the FFM for CHIP eligibility.

(a) The agreement must provide for the exchange of file data and eligibility status information between the [~~D~~]department and the FFM as required to determine eligibility and enrollment in insurance affordability programs, and eligibility for advance premium tax credits and reduced cost sharing.

(b) The agreement applies to agencies under contract with the [~~D~~]department to provide CHIP eligibility determination services.

(6) The [~~D~~]department and the eligibility agency shall release information to the Title IV-D agency and Social Security Administration to determine benefits.

**R382-10-6. Citizenship and Alienage.**

(1) To be eligible to enroll in CHIP, a child must be a United States (US) citizen, a US national, or a qualified alien.

(2) Section R414-302-3, regarding citizenship and alien status requirements, applies to CHIP applicants and members.

(3) The department elects to cover an applicant and a member who are under 19 years of age and lawfully present as defined in 42 U.S.C. 1396b(v) and 42 U.S.C. 1397gg(e)(1), and referenced in Section CS18 of the Utah CHIP State Plan.

**R382-10-7. Utah Residence.**

(1) The [~~Department adopts and incorporates by reference,~~]department complies with 42 CFR 457.320(d[~~), October 1, 2012 ed~~]) in regard to coverage related to citizenship and immigration status. A child must be a Utah resident to be eligible to enroll in the program.

(2) An American Indian or Alaska Native child in a boarding school is a resident of the state where [~~his~~]the child's parents reside. A child in a school for the deaf and blind is a resident of the state where [~~his~~]the child's parents reside.

(3) A child is a resident of the state if [~~he~~]the child is temporarily absent from Utah due to employment, schooling, vacation, medical treatment, or military service.

(4) The child need not reside in a home with a permanent location or fixed address.

**R382-10-8. Residents of Institutions.**

(1) Residents of institutions described in Section 2110(b)(2)(A) of the Compilation of Social Security Laws are not eligible for the program.

(2) A child under the age of 18 is not a resident of an institution if [~~he~~]the child is living temporarily in the institution while arrangements are being made for other placement.

(3) A child who resides in a temporary shelter for a limited period [~~of time~~ ]is not a resident of an institution.

**R382-10-9. Social Security Numbers.**

(1) The eligibility agency may request an applicant to provide the correct Social Security Number (SSN) or proof of application for a SSN for each household member [~~at the time of application~~]when applying for the program. The eligibility agency shall use the SSN in accordance with the requirements of 42 CFR 457.340(b[~~), October 1, 2012 ed., which is incorporated by reference.~~]).

(2) The eligibility agency shall require that each applicant claiming to be a [~~U.S.~~]US citizen or national provide their SSN [~~for the purpose of verifying~~]to verify citizenship through the Social Security Administration in accordance with Section 2105(c)(9) of the Compilation of the Social Security Laws.

(3) The eligibility agency may request the SSN of a lawful permanent resident alien applicant[~~,~~] but may not deny eligibility for failure to provide an SSN.

(4) The [~~D~~]department may assign a unique CHIP identification number to an applicant or beneficiary who meets one of the exceptions to the requirement to provide an SSN.

**R382-10-10. Creditable Health Coverage.**

(1) To be eligible for enrollment in the program, a child must meet the requirements of Section[~~s~~] 2110(b) of the Compilation of Social Security Laws.

(2) A child who is covered under a group health plan or other health insurance that provides coverage in Utah, including coverage under a parent's or legal guardian's employer, as defined in 29 CFR 2590.701-4[~~, July 1,~~ ] (2013[~~ ed.,~~]) is not eligible for CHIP assistance.

(3) A child who has access to health insurance coverage, where the cost to enroll the child in the least expensive plan offered by the employer is less than 5% of the countable MAGI-based income for the individual, is not eligible for CHIP. The child is considered to have access to coverage even when the employer only offers coverage during an open enrollment period, and the child has had at least one chance to enroll.

(4) An eligible child who has access to an employer-sponsored health plan, where the cost to enroll the child in the least expensive plan offered by the employer equals or exceeds 5% of the countable MAGI-based income for the individual may choose to enroll in either CHIP or UPP.

(a) To enroll in UPP, the child must meet UPP eligibility requirements.

(b) If the UPP eligible child enrolls in the employer-sponsored health plan or COBRA coverage, but the plan does not include dental benefits, the child may receive dental-only benefits through CHIP.

(c) If the employer-sponsored health plan or COBRA coverage includes dental, the applicant may choose to enroll the child in the dental plan and receive an additional reimbursement from UPP, or receive dental-only benefits through CHIP.

(d) A child enrolled in CHIP who gains access to or enrolls in an employer-sponsored health plan may switch to the UPP program if the child meets UPP eligibility requirements.

(5) The cost of coverage includes[~~ the following~~]:

(a) the premium;

(b) a deductible, if the employer-sponsored plan has a deductible; and

(c) the cost to enroll the employee, if the employee must be enrolled to enroll the child.

(6) Subject to [~~the provisions published in~~ ]42 CFR 457.805(b),[~~ October 1, 2015 ed., which the Department adopts and incorporates by reference,~~] the eligibility agency shall deny eligibility and impose a 90-day waiting period for enrollment under CHIP if the applicant or a custodial parent voluntarily terminates health insurance that provides coverage in Utah within the 90 days before the application date. In addition, the agency may not apply a 90-day waiting period in the following situations:

(a) a non-custodial parent voluntarily terminates coverage;

(b) the child is voluntarily terminated from insurance that does not provide coverage in Utah;

(c) the child is voluntarily terminated from a limited health insurance plan;

(d) a child is terminated from a custodial parent's insurance because ORS reverses the forced enrollment requirement due to the insurance being unaffordable;

(e) voluntary termination of COBRA;

(f) voluntary termination of Utah Comprehensive Health Insurance Pool coverage; or

(g) voluntary termination of UPP reimbursed, employer-sponsored coverage.

(7) If the 90-day ineligibility period for CHIP ends in the month of application, or by the end of the month that follows, the eligibility agency shall determine the applicant's eligibility.

(a) If eligible, enrollment in CHIP begins the day after the 90-day ineligibility period ends.

(b) If the 90-day ineligibility period does not end by the end of the month that follows the application month, the eligibility agency shall deny CHIP eligibility.

(8) The [~~D~~]department shall comply with [~~the provisions of~~ ]enrollment after the waiting period as described in [~~accordance with~~ ]42 CFR 457.340[~~, October 1, 2015 ed., which the Department adopts and incorporates by reference~~].

(9) A child with creditable health coverage operated or financed by Indian Health Services is not excluded from enrolling in CHIP.

(10) A child who has access to state- employee health insurance as defined in 42 CFR 457.310 is not eligible for CHIP assistance.

**R382-10-11. Household Composition and Income Provisions.**

(1) The [~~Department adopts and incorporates by reference,~~]department shall comply with 42 CFR 457.315 [~~(October 1, 2015),~~ ]regarding[ ~~the~~] household composition and income methodology to determine eligibility for CHIP.

(a) The eligibility agency shall count in the household size, the number of unborn children that a pregnant household member expects to deliver.

(b) The [~~D~~]department elects the option in 42 CFR 435.603(f)(3)(iv)(B).

(c) The eligibility agency will treat separated spouses, who are not living together, as separate households.

(2) Any individual described in Subsection R382-10-11(1) who is temporarily absent solely by reason of employment, school, training, military service, or medical treatment, or who will return home to live within 30 days from the date of application, is part of the household.

(3) The eligibility agency may not count as income any payments from sources that federal law specifically prohibits from being counted as income to determine eligibility for federally[-] funded programs.

(4) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian Money Account Litigation Settlement under the Claims Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(5) The eligibility agency shall count as income cash support received by an individual when:

(a) it is received from the tax filer who claims a tax exemption for the individual;

(b) the individual is not a spouse or child of the tax filer; and

(c) the cash support exceeds a nominal amount set by the [~~D~~]department.

(6) The eligibility agency determines eligibility by deducting an amount equal to 5% of the federal poverty guideline, as defined in 42 CFR 435.603(d)(4).

**R382-10-12. Age Requirement.**

(1) A child must be under 19 years of age sometime during the application month to enroll in the program. An otherwise eligible child who turns 19 years of age during the application month may receive CHIP for the application month and the four-day grace period.

(2) The month in which a child turns 19 years of age is the last month of eligibility for CHIP enrollment.

**R382-10-13. Budgeting.**

(1) The eligibility agency determines countable household income according to MAGI-based methodology as required by 42 CFR 457.315.

(2) The eligibility agency shall determine a child's eligibility and cost sharing requirements prospectively for the upcoming eligibility period [~~at~~]when the [~~time of application~~]child applies and at each renewal for continuing eligibility.

(a) The eligibility agency determines prospective eligibility by using the best estimate of the household's average monthly income expected to be received or made available to the household during the upcoming eligibility period.

(b) The eligibility agency shall include in its estimate[~~,~~] reasonably predictable income changes such as seasonal income or contract income, to determine the average monthly income expected to be received during the certification period.

(c) The eligibility agency prorates income that is received less often than monthly over the eligibility period to determine an average monthly income.

(3) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing. The eligibility agency may use a combination of methods to obtain the most accurate best estimate. The best estimate may be a monthly amount that is expected to be received each month of the eligibility period, or an annual amount that is prorated over the eligibility period. Different methods may be used for different types of income received in the same household.

(4) The eligibility agency determines farm and self-employment income by using the individual's recent tax return forms or other verifications the individual can provide. If tax returns are not available[~~,~~] or are not reflective of the individual's current farm or self-employment income, the eligibility agency may request income information from a recent [~~time~~ ]period during which the individual had farm or self-employment income. The eligibility agency deducts the same expenses from gross income that the Internal Revenue Service allows as self-employment expenses to determine net self-employment income[~~,~~] if those expenses are expected to occur in the future.

**R382-10-14. Assets.**

An asset test is not required for CHIP eligibility.

**R382-10-15. Application and Eligibility Reviews.**

(1) The department conducts application and eligibility reviews in accordance with 42 CFR 457.330, 457.340, 457.343, and 457.348.

(2) Section R414-308-3 applies to applicants for CHIP, except for Subsection R414-308-3(9) and except for the three months of retroactive coverage.

(3) An individual can apply without having an interview.

(4) The eligibility agency may interview an applicant, a member, the parents or spouse, and any adult who assumes responsibility for the care or supervision of the child to resolve discrepancies or to gather information that cannot be obtained otherwise.

(5) The eligibility agency shall complete a periodic review of a member's eligibility for CHIP medical assistance in accordance with 42 CFR 457.343.

(6)(a) If a member fails to respond to a request for information to complete the review during the review month, the agency shall end the member's eligibility effective at the end of the review month and send proper notice to the member.

(b) If the member responds to the review or reapplies within three calendar months of the review closure date, the eligibility agency shall treat the response as a new application without requiring the member to reapply. The application processing period then applies for this new request for coverage.

(c) If the member is determined eligible based on this reapplication, the new certification period begins the first day of the month that the member contacts the agency to complete the review if verification is provided within the application processing period.

(i) Under these circumstances, the four-day grace period may apply.

(ii) If the member fails to return verification within the application processing period, or if the member is determined ineligible, the eligibility agency shall send a denial notice to the member.

(d) The eligibility agency may not continue eligibility while it makes a new eligibility determination.

(7) Except as defined in Subsection R382-10-15(5), the member must reapply for CHIP if the member's case is closed for one or more calendar months.

(8) If the eligibility agency sends proper notice of an adverse decision during the review month, the agency shall change eligibility for the month that follows.

(9) If the eligibility agency does not send proper notice of an adverse change for the month that follows, the agency shall extend eligibility to that month. The eligibility agency shall send proper notice of the effective date of an adverse decision.

(10) If the member responds to the review in the review month and the verification due date is in the month that follows, the eligibility agency shall extend eligibility to the month that follows. The member must provide verification by the verification due date.

(a) If the member provides requested verification by the verification due date, the eligibility agency shall determine eligibility and send proper notice of the decision.

(b) If the member does not provide requested verification by the verification due date, the eligibility agency shall end eligibility effective at the end of the month that the eligibility agency sends proper notice of the closure.

(c) If the member returns verification after the verification due date and before the effective closure date, the eligibility agency shall treat the date it receives verification as a new application date. The eligibility agency shall determine eligibility and send a notice to the member.

(11) The eligibility agency may not continue eligibility while it determines eligibility. The new certification date for the application is the day after the effective closure date if the member is found eligible.

(12) The eligibility agency shall provide ten-day notice of case closure if the member is determined to be ineligible or if the member fails to provide verification by the verification due date.

(13) If eligibility for CHIP enrollment ends, the eligibility agency shall review the case for eligibility under any other medical assistance program without requiring a new application. The eligibility agency may request additional verification from the household if there is insufficient information to determine eligibility.

(14) An applicant must report at application and review whether any of the children in the household for whom enrollment is being requested have access to or are covered by a group health plan, other health insurance coverage, or a state employee's health benefits plan.

(15) The eligibility agency shall deny an application or review if the member fails to respond to questions about health insurance coverage for any children for whom the household seeks to enroll or renew in the program.

**R382-10-16. Eligibility Decisions.**

(1) The [~~Department adopts and incorporates by reference~~]department shall comply with 42 CFR 457.350[~~, October 1, 2013, ed.,~~] regarding eligibility screening.

(2) The eligibility agency shall determine eligibility for CHIP within 30 days of the date of application. If the eligibility agency cannot [~~make a decision~~]decide in 30 days because the applicant fails to take a required action and requests additional time to complete the application process, or if circumstances beyond the eligibility agency's control delay the eligibility decision, the eligibility agency shall document the reason for the delay in the case record.

(3) The eligibility agency may not use the time standard as a waiting period before determining eligibility, or as a reason for denying eligibility when the agency does not determine eligibility within that time.

(4) The eligibility agency shall complete a determination of eligibility or ineligibility for each application unless:

(a) the applicant voluntarily withdraws the application and the eligibility agency sends a notice to the applicant to confirm the withdrawal;

(b) the applicant died; or

(c) the applicant cannot be located or does not respond to requests for information within the 30-day application period.

(5) The eligibility agency shall redetermine eligibility every 12 months.

(6) At application and review, the eligibility agency shall determine if any child applying for CHIP enrollment is eligible for coverage under Medicaid.

(a) A child who is eligible for Medicaid coverage is not eligible for CHIP.

(b) An eligible child who must meet a spenddown to receive Medicaid and chooses not to meet the spenddown may enroll in CHIP.

(7) If an enrollee asks for a new income determination during the CHIP certification period and the eligibility agency finds the child is eligible for Medicaid, the agency shall end CHIP coverage and enroll the child in Medicaid.

**R382-10-17. Effective Date of Enrollment and Renewal.**

(1) Subject to the limitations in Sections R414-306-6[~~, Section~~] and R382-10-10[~~,~~] and[~~the provisions~~] in Subsection R414-308-3(7), the effective date of CHIP enrollment is the first day of the application month.

(2) If the eligibility agency receives an application during the first four days of a month, the agency shall allow a grace enrollment period that begins no earlier than four days before the date that the agency receives a completed and signed application.

(a) If the eligibility agency allows a grace enrollment period that extends into the month before the application month, the days of the grace enrollment period do not count as a month in the 12-month enrollment period.

(b) During the grace enrollment period, the individual must receive medical services, meet eligibility criteria, and have an emergency situation that prevents the individual from applying. The [~~D~~]department may not pay for any services that the individual receives before the effective enrollment date.

(3) For a family who has a child enrolled in CHIP and who adds a newborn or adopted child, the effective date of enrollment is the date of birth or placement for adoption if the family requests the coverage within 60 days of the birth or adoption. If the family makes the request more than 60 days after the birth or adoption, enrollment in CHIP becomes effective the first day of the month in which the date of report occurs, subject to the limitations in Sections R414-306-6[~~, Section~~] and R382-10-10, and[~~the provisions of~~] Subsection R382-10-17(2).

(4) For an individual who transfers from the [~~Federally Facilitated Marketplace (~~]FFM[~~),~~], the effective date of enrollment to add a newborn or adopted child is the date of birth or placement for adoption if the individual requests FFM coverage within 60 days of the birth or adoption. If the request is more than 60 days after the birth or adoption, enrollment in CHIP becomes effective the first day of the month in which the date of report occurs, subject to the limitations in Sections R414-306-6[~~, Section~~] and R382-10-10, and[~~the provisions of~~] Subsection R382-10-17(2).

(5) The effective date of enrollment for a new certification period after the review month is the first day of the month after the review month, if the review process is completed by the end of the review month. If a due process month is approved, the effective date of enrollment for a renewal is the first day of the month after the due process month if the review process is completed by the end of the due process month. The enrollee must complete the review process and continue to be eligible to be reenrolled in CHIP at review.

**R382-10-18. Enrollment Period and Benefit Changes.**

(1) Subject to Subsection (2), a child determined eligible for CHIP receives 12 months of coverage that begins with the effective month of enrollment.

(2) CHIP coverage may end or change before the end of the 12-month certification period if the child:

(a) turns 19 years of age;

(b) moves out of the state;

(c) becomes eligible for Medicaid;

(d) leaves the household;

(e) is not eligible, or is eligible for a different plan due to a change described in Subsection R382-10-4(6)(b);

(f) enters a public institution or an institution for mental disease;[~~or~~]

(g) fails to respond to a request to verify reportable changes as described in Subsection R382-10-4(6)(b); or

(h) gained lawfully present eligibility as defined in Subsection R382-10-6(3), and subsequently lost lawfully present status.

(3) A child who becomes pregnant while enrolled in the program retains eligibility for the [~~remainder~~]rest of the pregnancy and the 12-month post-partum period.

(4) The agency evaluates changes and may redetermine eligibility when it receives a change report as described in Subsection R382-10-4(6). If the agency requests verification of the change, the agency shall give the member at least ten days to provide verification. The agency shall provide proper notice of an adverse action.

(5) If a member reports a change that occurs during the certification period and requests a redetermination, the agency shall redetermine eligibility.

(a) If a member gains access to health insurance under an employer-sponsored plan or COBRA coverage, the member may switch to UPP. The member must report the health insurance within ten calendar days of enrolling, or within ten calendar days of when coverage begins, whichever is later. The employer-sponsored plan must meet UPP criteria.

(b) If the change would cause an adverse action, eligibility would remain unchanged through the end of the certification period.

**State of Utah**
**Administrative Rule Analysis**
Revised May 2024

| NOTICE OF SUBSTANTIVE CHANGE | | |
|---|---|---|
| **TYPE OF FILING:** Amendment | | |
| **Rule or Section Number:** | **R414-1-32** | **Filing ID: 56919** |

**Agency Information**

| | | |
|---|---|---|
| **1. Title catchline:** | Health and Human Services, Integrated Healthcare | |
| **Building:** | Cannon Health Building | |
| **Street address:** | 288 N. 1460 W. | |
| **City, state** | 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 |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |
| **Please address questions regarding information on this notice to the persons listed above.** | | |

**General Information**

**2. Rule or section catchline:**

R414-1-32. Prior Authorization from Primary Payers First

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

The purpose of this change is to encourage health care providers to seek prior authorization from a primary payer before seeking third party liability through Medicaid. This change also has the effect of prohibiting health insurance entities from denying a claim submitted by the Department of Health and Human Services or the department's contractor based solely on the lack of prior authorization. Both changes are in accordance with changes made to Subsection 26B-3-1004 as a result of HB501 from the 2024 General Session.

**4. Summary of the new rule or change:**

This amendment adds language in Section R414-1-32 to encourage health care providers to seek prior authorization from a primary payer before seeking payment through Medicaid and prohibit health insurance entities from denying a claim submitted by the department or the department's contractor based solely on the lack of prior authorization.

**Fiscal Information**

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

**A) State budget:**

The Department of Health and Human Services (DHHS) expects Medicaid recovery collections to increase because insurance companies will not be able to deny claims from the Office of Recovery Services for failure to seek pre-authorization, as they had been previous to this filing. Using data available to DHHS for the fiscal response to HB501, the department expects the following fiscal impacts as a result of this rule. Relying on FY2023 data, based on the number of health claim debts referred by Medicaid, average collections per debt, and the number of debts for which no payment was received, approximately two-thirds of which have historically been denied due to no prior authorization, this fiscal impact is estimated to be approximately $15.7 million dollars collected from health insurance companies and returned to each member's respective Medicaid program.

**B) Local governments:**

There is no anticipated fiscal impact on local governments, as this proposed section does not apply to this group. There are no identified local governments that would need to add to, remove, or modify processes as a result of this filing.

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

113 health insurance companies have been identified as small businesses (NAICS 524114) and will not be able to use the lack of prior authorization as a pro forma denial for Medicaid claims. These 113 companies are estimated to have 16% of the employees within Utah's health insurance industry and 16% of the $15.7 million costs estimated for the industry as a whole, or

an estimated $2,530,000 to small business health insurance companies as a direct result of not being able to deny claims solely for a lack of prior authorization.

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

10 health insurance companies have been identified as non-small businesses (NAICS 524114) and will not be able to use the lack of prior authorization as a pro forma denial for Medicaid claims. These 10 companies are estimated to have 84% of the employees within Utah's health insurance industry and 84% of the $15.7 million costs estimated for the industry as a whole, or an estimated $13,170,000 to non-small business health insurance companies as a direct result of not being able to deny claims solely for a lack of prior authorization.

**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 anticipated fiscal impact on other persons, as this proposed section does not apply to this group. There are no identified other persons who would need to add to, remove, or modify responsibilities as a result of this filing.

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

Small and non-small business health insurance companies are identified as affected persons for this filing. The compliance cost will be the same, regardless of whether the health insurance company is considered a small or non-small business. On average, a claim denied before this filing would cost a health insurance company approximately $1,000 per debt. Any processing costs are inestimable, as they vary depending on the business, client, and claim. Any other group fiscally impacted by this rule is not anticipated to incur a compliance cost.

**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** | **FY2025** | **FY2026** | **FY2027** |
|---|---|---|---|
| State Government | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 |
| Small Businesses | $2,530,000 | $2,530,000 | $2,530,000 |
| Non-Small Businesses | $13,170,000 | $13,170,000 | $13,170,000 |
| Other Persons | $0 | $0 | $0 |
| **Total Fiscal Cost** | **$0** | **$0** | **$0** |
| **Fiscal Benefits** | **FY2025** | **FY2026** | **FY2027** |
| State Government | $15,700,000 | $15,700,000 | $15,700,000 |
| 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.

**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 | Section 26B-3-1004 |

**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:** | 12/16/2024 |

| | |
|---|---|
| **9. This rule change MAY become effective on:** | 12/23/2024 |
| 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**

| | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Executive Director | **Date:** | 11/01/2024 |

**R414. Health and Human Services, Integrated Healthcare.**
**R414-1. Utah Medicaid Program.**
**R414-1-32. Prior Authorization from Primary Payers First.**

(1) Health care providers are encouraged to seek prior authorization, when necessary, from a health insurance entity that is the primary payer before seeking third-party liability through Medicaid.

(2) A health insurance entity may not deny a claim submitted by the Office of Recovery Services, the Office of Inspector General of Medicaid Services, Medicaid, or an authorized contractor for an item or service based solely on a lack of prior authorization.

**KEY: Medicaid**
**Date of Last Change: [~~December 6, 2023~~]2024**
**Notice of Continuation: December 13, 2021**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108; 26B-8-132; 26B-3-1004**

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(c) If the change makes the enrollee eligible for Medicaid, the eligibility agency shall end CHIP eligibility and enroll the child in Medicaid.

(6) Failure to make a timely report of a reportable change may result in an overpayment of benefits and case closure.

**R382-10-19. Termination and Notice.**

(1) The eligibility agency shall notify an applicant or member in writing of the eligibility decision made on the application or periodic eligibility review.

(2) The eligibility agency shall notify a member in writing ten calendar days before the effective date of an action that adversely affects the member's eligibility.

(3) The eligibility agency shall provide the following information:

(a) the action to be taken;

(b) the reason for the action;

(c) the [~~regulations~~]criteria or policy that support the action when the action is a denial, closure, or an adverse change to eligibility;

(d) the applicant's or member's right to a hearing;

(e) how an applicant or [~~member~~ ]may request a hearing; and

(f) the applicant's or[ ~~member's~~] right to represent themselves or use legal counsel, a friend, relative, or other spokesperson.

(4) The eligibility agency need not give ten-day notice of termination if:

(a) the child is deceased;

(b) the child moves out[**-**] of state and is not expected to return;

(c) the child enters a public institution or an institution for mental disease; or

(d) the child's whereabouts are unknown and the post office has returned mail to show that there is no forwarding address.

**R382-10-20. Case Closure or Withdrawal.**

(1) The eligibility agency shall end a child's enrollment upon enrollee request or upon discovery that the child is no longer eligible. An applicant may withdraw an application for CHIP benefits any time before the eligibility agency decides on the application.

(2) The eligibility agency shall comply with the requirements of 42 CFR 457.350(i), regarding transfer of the electronic file to determine eligibility for other insurance affordability programs.

**[~~R382-10-21. Public Health Emergency Provisions.~~**

~~(1) During the public health emergency declared by the Secretary of Health and Human Services on January 27, 2020, the department will continue coverage of children enrolled in CHIP.~~

~~(a) This applies to an individual who is eligible and enrolled on March 18, 2020, the date of enactment of Pub. L. No. 116-127, or who subsequently becomes eligible and enrolled in medical assistance during the emergency period and any extensions.~~

~~(b) Coverage for an individual eligible for CHIP during the public health emergency period will end only under the following circumstances:~~

~~(i) when a beneficiary is no longer a Utah resident;~~

~~(ii) upon a beneficiary's request; or~~

~~(iii) upon a beneficiary's death. Coverage continues through the date of death.~~

~~(2) An individual is not required to pay CHIP Premiums through the duration of the emergency period and any extensions. The department will refund the individual any premiums collected during the emergency period and any extensions.~~

~~(3) The department shall exclude the following from an individual's income:~~

~~(a) $600 per week federal pandemic unemployment payments as defined in Section 2102 and 2104(b) of the Coronavirus Aid, Relief, and Economic Security (Cares) Act, Pub. L. No. 116-136, for programs established under Title XXI of the Social Security Act; and~~

~~(b) recovery rebates for individuals as defined in Section 2201 of the Cares Act, Pub. L. No. 116-136, for programs established under Title XXI of the Social Security Act. These rebates are treated as a refundable tax credit and may be paid in advance or upon filing a 2020 tax return.~~

~~(4) The department shall exclude from income certain employer payments of student loans as defined in Section 2206 of the Cares Act, Pub. L. No. 116-136.~~

~~(a) Payments toward an employee's student loans may be paid directly to the employee or to the lender.~~

~~(b) This exclusion applies to payments made on or after the effective date of Pub. L. No. 116-136 and before January 1, 2021.~~

~~(5) The department shall exclude the amount of qualified charitable contributions made by individuals during the taxable year as defined in Section 2204 of the Cares Act, Pub. L. No. 116-136.~~

~~(a) Allowable taxable years begin in the year 2020.~~

~~(b) The excluded contributions must not exceed $300.~~

~~(6) An individual is not required to pay any cost-sharing fees associated with Coronavirus (COVID-19) testing services and treatments, including vaccines, specialized equipment, and therapies during the duration of the emergency period.~~

**]KEY: children's health benefits**
**Date of Last Change: [~~July 1,~~ ]2024**
**Notice of Continuation: April 10, 2023**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-902**

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**State of Utah**
**Administrative Rule Analysis**
Revised May 2024

| NOTICE OF SUBSTANTIVE CHANGE | | |
|---|---|---|
| **TYPE OF FILING:** Amendment | | |
| **Rule or Section Number:** | **R414-40-3** | **Filing ID: 56915** |

**Agency Information**

| | | |
|---|---|---|
| **1. Title catchline:** | Health and Human Services, Integrated Healthcare | |
| **Building:** | Cannon Health Building | |
| **Street address:** | 288 N. 1460 W. | |
| **City, state:** | Salt Lake City, UT | |
| **Mailing address:** | PO Box 143325 | |
| **City, state and zip:** | Salt Lake City, UT 84114-3325 | |
| **Contact persons:** | | |
| **Name:** | **Phone:** | **Email:** |
| Craig Devashrayee | 801-538-6641 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |
| **Please address questions regarding information on this notice to the persons listed above.** | | |

**General Information**

**2. Rule or section catchline:**

R414-40-3. Program Access Requirements

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

The purpose of this change is to update and clarify current policy for provider requests of prior authorization for private duty nursing services, as a result of internal agency review. Detailed requirements and procedures may be found in Home Health Agencies Utah Medicaid Provider Manual.

**4. Summary of the new rule or change:**

This amendment removes the requirement for providers to submit initial prior authorization requests and removes the requirement for home health agencies to submit an initial certification and recertification at least every 60 days. Detailed requirements and procedures may be found in Home Health Agencies Utah Medicaid Provider Manual. Additionally, this amendment makes style and formatting changes to comply with the Rulewriting Manual for Utah.

**Fiscal Information**

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

**A) State budget:**

There is no anticipated fiscal impact on the state budget as this change updates existing policy that neither affects services nor payment. There are no administrative costs or savings associated with the removal of these provisions.

**B) Local governments:**

There is no anticipated fiscal 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 anticipated fiscal impact on small businesses as this change updates existing policy that neither affects services nor payment. There are no administrative costs or savings associated with the removal of these provisions.

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

There is no anticipated fiscal impact on non-small businesses as this change updates existing policy that neither affects services nor payment. There are no administrative costs or savings associated with the removal of these provisions.

**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 anticipated fiscal impact on other persons or entities as this change updates existing policy that neither affects services nor payment. There are no administrative costs or savings associated with the removal of these provisions.

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

There is no anticipated compliance cost for affected persons as this change updates existing policy that neither affects services nor payment. There are no administrative costs or savings associated with the removal of these provisions.

**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** | **FY2025** | **FY2026** | **FY2027** |
|---|---|---|---|
| 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** | **FY2025** | **FY2026** | **FY2027** |
| 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.

**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:** | 12/16/2024 |

| | |
|---|---|
| **9. This rule change MAY become effective on:** | 12/23/2024 |

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

**Agency Authorization Information**

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

| | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Executive Director | **Date:** | 10/31/2024 |

**R414. Health and Human Services, Integrated Healthcare.**
**R414-40. Private Duty Nursing Services.**
**R414-40-3. Program Access Requirements.**

(1) Only a licensed home health agency enrolled as a Medicaid provider may be reimbursed for private duty nursing services.

(2) A member [~~must~~]shall have a written physician order establishing the need for private duty nursing services. [-]The private duty nursing provider [~~must~~]shall develop a care plan consistent with the member's diagnosis, [~~the~~ ]severity of illness, and intensity of services. [-]If medically necessary nursing services require four hours or [~~less~~]fewer of skilled nursing, the service is covered under the home health program.

[~~(3) Medicaid providers shall submit an initial prior authorization request with medical documentation that demonstrates the need for nursing services. The home health agency shall submit an initial certification and recertification at least every 60 days as required by 42 CFR 440.70.~~]

([~~4~~]3) Private duty nursing is only available if a parent, guardian, or primary caregiver is committed to and capable of performing the medical skills necessary to ensure safe, quality care.

([~~5~~]4)(a) The home health agency shall verify that the hospital has provided specialized training for the caregiver before patient discharge to enable the caregiver to provide hands-on care in the home.

(b) The private duty nurse shall initially supervise[~~s~~] the caregiver who provides this care to ensure that training has been assimilated to ensure safe, quality patient care.

**KEY: Medicaid**
**Date of Last Change: 2024[~~November 10, 2023~~]**
**Notice of Continuation: April 28, 2020**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108**

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