DIH Rules Matrix 6-20-24

Rule Summary	Bulletin Publication	Effective
R414-526 Quality Standards for Inpatient and Outpatient Hospitals (Change in Proposed Rule); Based on public comment and internal review, the purpose of this change in proposed rule (CPR) is to clarify provisions for accountable care organizations (ACOs) and quality measures for hospitals in accordance with the Hospital Provider Assessment. This CPR clarifies provisions for metrics, data submission, penalties, and final determinations as they relate to the payment rate structure for ACOs and quality measures for hospitals. It also makes other grammatical and restructuring changes.	**5-1-24**	**6-7-24**
R414-7A Medicaid Certification of New Nursing Facilities (Five-Year Review); The department will continue this rule because it implements the adjudicative process to administer Medicaid certification of nursing facility programs.	**6-15-24**	**5-17-24**
R414-31 Inpatient Psychiatric Services for Individuals Under 21 Years of Age (Five-Year Review); The department will continue this rule because it sets forth conditions and coverage for inpatient psychiatric services for individuals under 21 years of age, which the state has elected to cover.	**6-15-24**	**5-29-24**
R414-49 Dental, Oral, and Maxillofacial Surgeons and Orthodontia (Five-Year Review); The department will continue this rule because it provides a scope of dental services for members who are eligible under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, pregnant members, blind or disabled members, aged members, members of the targeted adult Medicaid population, and members who are otherwise eligible under Medicaid and qualify for emergency dental.	**6-15-24**	**5-29-24**
R414-502 Nursing Facility Levels of Care (Five-Year Review); The department will continue this rule because it defines the levels of care that nursing facilities may provide for Medicaid members.	**6-15-24**	**5-29-24**
R414-503 Preadmission Screening and Resident Review (Five-Year Review); The department will continue this rule because it implements the required preadmission screening and resident review of nursing facility residents with serious mental illness or intellectual disability.	**6-15-24**	**5-29-24**
R414-36 Rehabilitative Mental Health and Substance Use Disorder Services (Five-Year Review); The department will continue this rule because it implements rehabilitative mental health and substance use disorder services as described in the Medicaid provider manual and in the Medicaid State Plan.	**7-1-24**	**6-4-24**
R414-140 Choice of Healthcare Delivery Program (Five-Year Review); The department will continue this rule because it sets forth requirements and coverage for Medicaid members under the Choice of Healthcare Delivery Program.	**7-1-24**	**6-4-24**
R414-501 Preadmission Authorization, Retroactive Authorization, and Continued Stay Review (Five-Year Review); The department will continue this rule because it implements nursing facility and utilization requirements for continued stays in nursing facilities.	**7-1-24**	**6-4-24**

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

NOTICE OF CHANGE IN PROPOSED RULE		
Rule or Section Number:	**R414-526**	**Filing ID: 56067**
Date of Previous Publication:	**11/15/2023**	

Agency Information

1. Department:	Health and Human Services	
Agency:	Integrated Healthcare	
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
Mariah Noble	801-538-6111	mariahnoble@utah.gov

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

General Information

2. Rule or section catchline:

R414-526. Quality Standards for Inpatient and Outpatient Hospitals

3. Reason for this change:

Based on public comment and internal review, the purpose of this change in proposed rule (CPR) is to clarify provisions for accountable care organizations (ACOs) and quality measures for hospitals in accordance with Title 26B, Chapter 3, Part 7, Hospital Provider Assessment.

4. Summary of this change:

This CPR clarifies provisions for metrics, data submission, penalties, and final determinations as they relate to the payment rate structure for ACOs and quality measures for hospitals. It also makes other grammatical and restructuring changes.

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 to the state budget, as this CPR clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule has already accounted for any fiscal impact to the state budget.

B) Local government:

There is no anticipated impact on local governments, as they neither fund nor provide hospital services under the Medicaid program.

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

There is no anticipated impact on small businesses as this CPR clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule has already accounted for the fiscal impact on small businesses.

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

There is no anticipated impact on non-small businesses, as this CPR clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule has already accounted for the fiscal impact on non-small businesses.

E) Persons other than small businesses, non-small businesses, or 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 impact on other persons, as this CPR clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule has already accounted for the fiscal impact on other persons or entities.

F) Compliance costs for affected persons:

As there is no anticipated impact on other persons, there are no compliance costs, as this change clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule has already accounted for the fiscal impact on a single person or entity.

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

Regulatory Impact Table

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

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

The Executive Director of the Department of Health and Human Services, Tracy 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	Title 26B, Chapter 3, Part 7

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//2024

9. This rule change MAY become effective on:	06/07/2024

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:**	04/25/2024

R414. Health and Human Services, Integrated Healthcare.
R414-526. Quality Standards for Inpatient and Outpatient Hospitals.
R414-526-1. Introduction and Authority.

The purpose of this rule is to incorporate certain factors into the payment rate structure for accountable care organizations (ACOs), [~~and~~]to establish quality measures [~~and penalties~~]for hospital[~~s that perform~~] inpatient and outpatient services, and to establish corresponding performance penalties for hospitals as directed in Title 26B, Chapter 3, Part 7, Hospital Provider Assessment.

R414-526-2. Definitions.

For purposes of this rule, the following definitions apply.

(1) "Directed payment" means a payment arrangement authorized by CMS that permits the department to direct specific payments made by a managed care plan to providers.

(2[~~1~~]) "Improvement margin" means a percentage determined by the department after consulting with hospitals and in accordance with evidence-based guidelines and national benchmarks.

(3[~~2~~]) "Rural hospital" means a general acute hospital in a rural setting, [~~with the~~]except[~~ion of~~] for a specialty hospital.

(4[~~3~~]) "Specialty hospital" means a specialty hospital in an urban or rural setting as defined [~~by~~]in Section 26B-3-701.

(5[~~4~~]) "Urban hospital" means a diagnosis-related group (DRG)-reimbursed hospital in an urban setting, [~~with the~~]except[~~ion of~~] for a specialty hospital.

R414-526-3. Quality Metrics and Standards.

(1) The department shall determine hospital quality measures that correspond to hospital performance for directed payments.[~~The department adopts different quality standards for rural and specialty hospitals to address unique needs. The department uses the following categories for hospital quality measures and standards:~~

~~(a) urban hospitals;~~

~~(b) rural hospitals; and~~

~~(c) specialty hospitals.~~]

(2) The department may select different hospital quality measures for urban, rural, and specialty hospitals.[~~For each measure, a hospital is required:~~

~~(a) to score at or above the national average as identified by the Centers for Medicare and Medicaid Services; or~~

~~(b) improve on quality measure performance from the preceding state fiscal year (SFY).~~]

(3) The department shall select hospital quality measures appropriate to a hospital type and specialty.[~~Urban hospitals shall submit quality measures for the Medicaid population that include:~~

~~(a) a hospital-wide all-cause unplanned readmission rate within 30 days of discharge, which measures the provision of appropriate transitional care and discharge procedures to reduce the risk of unplanned hospital readmissions;~~

~~(b) the proportion of patients who sign in to be evaluated for emergency services, but left without being evaluated by a credentialed provider; and~~

~~(c) the ability to provide patients electronic access to timely, accurate, and comprehensive health information through an electronic portal.~~]

(4) For each measure, a hospital shall:

(a) perform at or above a national or state benchmark or;

(b) improve over its preceding state fiscal year (SFY) scores by an improvement margin defined by the department.[~~Rural hospitals shall submit quality measures for the Medicaid population that include:~~

~~(a) a hospital-wide all-cause unplanned readmission rate within 30 days of discharge, which measures the provision of appropriate transitional care and discharge procedures to reduce the risk of unplanned hospital readmissions;~~

~~(b) a median time for emergency department (ED) arrival to ED departure for discharged ED patients, which measures the average time patients spend in the ED before being sent home; and~~

~~(c) the ability to provide patients electronic access to timely, accurate, and comprehensive health information through an electronic portal.~~]

(5) The department requires only Medicaid-certified hospitals that receive directed payments to comply with this rule.[~~The department shall work with specialty hospitals to identify their quality measures before July 1, 2024.~~]

(6) Hospitals must meet targeted standards and improvement goals to receive full directed payments.

[~~(6)(a) The department requires Medicaid-certified hospitals that receive directed payments to submit calculated measures.~~

~~(b) These hospitals shall meet targeted standards and improvement goals to receive full direct payments.~~]

(7) The department shall continue directed payments during the period targeted standards and improvement goals are under development.

(8) The department shall develop a technical guide that includes details on the hospital quality measures, performance criteria, and penalties, and furnish the technical guide before the period for which performance is measured.

(9) Quality standards are not applicable to directed payments associated with Subsection 26B-3-707(1)(a) or other private and government hospital inpatient and outpatient directed payment levels in place at the end of SFY 2023.

(10) The department shall remove hospital quality standard requirements if directed payments, to which hospital quality performance are tied, are discontinued.

R414-526-4. Data Submission.

(1) In SFY 2024, each hospital shall engage in necessary activities to prepare for reporting on the quality measures to the department.[~~During SFY 2024, each hospital shall engage in necessary activities to prepare for reporting on the quality measures to the department. In addition, each hospital shall submit a quarterly report to the department describing the activities and progress toward reporting capability on the quality measures within ten business days of the end of each quarter for the preceding quarter.~~]

(a) In SFY 2024, each hospital shall submit a report to the department describing the activities and progress toward reporting capability on the quality measures within ten business days of the end of the SFY.

(2) In SFY 2025, the quality measure performance period will begin at the start of SFY 2025 and continue through the end of the third quarter of SFY 2025.

[~~(2) Each hospital shall submit their calculated quality measure data to the department within ten business days of the end of each subsequent SFY.~~](3) In SFY 2026, the quality measure performance period will begin at the start of the fourth quarter of SFY 2025 and continue through the end of the third quarter of SFY 2026.

(4) In subsequent state fiscal years, the quality measure performance period will begin at the start of the fourth quarter of the SFY and continue through the end of the third quarter of the following SFY.

(5) Each hospital shall submit quality measure data and other required reporting to the department within 30 business days following the end of the performance period unless otherwise specified.

(6) Specialty hospitals are exempt from these reporting timeframes until the department identifies quality measures for specialty hospitals and a timeframe for reporting by specialty hospitals is established.

R414-526-5. Penalties.

(1) The department shall determine penalties tied to hospital quality measure performance.[~~For each quality measure, the hospital shall meet a performance standard or be subject to penalties.~~]

(2) A hospital must meet a performance standard for each quality measure or be subject to penalty.[~~Penalty levels for urban and rural hospitals are as follows:~~

~~(a) an urban or rural hospital that performs at or above a national benchmark for quality measures, or improves over its preceding SFY quality measure scores by an improvement margin defined for each measure, receives no penalty;~~

~~(b) an urban or rural hospital that does not perform at or above a national benchmark or does not improve over its preceding SFY quality measure score by an improvement margin defined for the measure, on only one of three measures, is subject to a Level 1 penalty;~~

~~(c) an urban or rural hospital that does not perform at or above a national benchmark or does not improve over its preceding SFY quality measure score by an improvement margin defined for each measure, on two of three measures, is subject to a Level 2 penalty; or~~

~~(d) an urban or rural hospital that does not perform at or above a national benchmark or does not improve over its preceding SFY quality measure score by an improvement margin defined for each measure, on all three measures, is subject to a Level 3 penalty.~~]

(3) The following penalty levels apply for each hospital:[~~For SFY 2024 payments, the department does not apply penalties to urban and rural hospitals.~~]

(a) a hospital that performs at or above a national or state benchmark for quality measures or improves over its preceding SFY quality measure scores by an improvement margin defined for each measure receives no penalty;

(b) a hospital that has some combination of performance for quality measures that is at or above a national or state benchmark, improves over its preceding SFY quality measure score by an improvement margin defined for each measure, or makes incremental improvement toward the improvement margin defined for each measure is subject to a Level 1 penalty;

(c) a hospital that does not perform at or above a national or state benchmark, does not improve over its preceding SFY quality measure score by an improvement margin defined for each measure, and makes no incremental improvement toward the improvement margin defined for each measure is subject to a Level 2 penalty; and

(d) a hospital that does not submit its data timely to the department may receive a Level 2 penalty.

(4) The department will not apply penalties to a hospital in SFY 2024.[~~For SFY 2025 payments and beyond, the department assesses penalties to urban and rural hospitals by percentage as follows:~~

~~(a) Level 1 penalty equals 1% of the SFY directed payment amounts;~~

~~(b) Level 2 penalty equals 2% of the SFY directed payment amounts; and~~

~~(c) Level 3 penalty equals 4% of the SFY directed payment amounts.~~]

(5) In SFY 2025 and after, the department shall assess penalties through the following penalty percentages:

(a) penalties may not exceed 3% of a hospital's total SFY directed payment amount;

(b) a Level 1 penalty is assessed on a portion of the 3% of the SFY directed payment penalty as detailed in the department's technical guide;

(c) a Level 2 penalty equals 3% of the SFY directed payment amount; and

[~~(5) A hospital that does not timely submit its data to the department within ten business days of the end of the SFY shall receive a Level 3 penalty.~~]

(6) After calculating the interim-final directed payment for the SFY, the appropriate penalty will reduce the interim-final directed payment and will constitute the final directed payment for the SFY.

(a) If the resulting final directed payment is a negative value, that amount shall be payable by the hospital to the applicable ACO within 30 calendar days of notification from the department.

(b) If the hospital fails to pay the ACO within 30 days, the department may suspend future directed payments to the hospital until the hospital pays the full amount.

[~~(6)(a) After calculating the interim-final directed payment for the SFY, the appropriate penalty reduces the interim-final directed payment and constitutes the final directed payment for the SFY.~~

~~(i) If the resulting final directed payment is a positive value, the accountable care organization (ACO) shall pay the hospital within 30 calendar days of notification from the department.~~

~~(ii) If the resulting final directed payment is a negative value, that amount is payable by the hospital to the applicable ACO within 30 calendar days of notification from the department.~~

~~(c) If the hospital fails to pay the ACO within 30 days, the department may suspend future directed payments to the hospital until the ACO receives the full payment amount.~~]

(7) In SFY 2025, specialty hospitals shall be exempt from penalty.[~~In accordance with Subsection (6), the ACO shall pay the department the penalty amount it receives from the hospital within 30 calendar days of receipt.~~

~~(8) If the ACO fails to pay the department within 30 days, the department may suspend payments to the ACO until the department receives the full payment amount.~~

~~(9) For SFY 2024 and SFY 2025, specialty hospitals are penalty-exempt.~~]

R414-526-6. Final Determinations.

(1) A hospital may request the department to reconsider the assessment of a penalty.

(2) The department shall work with the hospital to address any disputes regarding performance and related penalties.

(3) The department shall make final determinations on hospital performance and penalty assessments.

KEY: Medicaid
Date of Last Change: 2024
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-7A**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Jonah Shaw	(385) 310-2389	jshaw@utah.gov
Jordan Miera	(801) 538-4171	jmiera@utah.gov

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

General Information

2. Rule catchline:

R414-7A. Medicaid Certification of New Nursing Facilities.

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

Section 26B-3-108 requires the Department to implement Medicaid through administrative rules, and Section 26B-1-213 grants the Department the authority to adopt, amend, or rescind these rules. Additionally, Section 26B-3-312 specifies that adjudicative decisions are subject to review and appeal.

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

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

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

The Department will continue this rule because it implements the adjudicative process to administer Medicaid certification of nursing facility programs.

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:**	05/06/2024

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

R414. Health and Human Services, Integrated Healthcare.
R414-7A. Medicaid Certification of New Nursing Facilities.
R414-7A-1. Administrative Proceedings.

Adjudicative proceedings for decisions by the Division of Integrated Healthcare, made pursuant to Section 26B-3-312, are informal and conducted in accordance with Rule R410-14.

KEY: Medicaid
Date of Last Change: November 10, 2023
Notice of Continuation: May 24, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-312(2)

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-31**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
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 catchline:
R414-31. Inpatient Psychiatric Services for Individuals Under 21 Years of Age.
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26B-3-108 requires the department to implement Medicaid through administrative rules, and Section 26B-1-213 grants the department the authority to adopt, amend, or rescind these rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The department will continue this rule because it sets forth conditions and coverage for inpatient psychiatric services for individuals under 21 years of age, which the state has elected to cover.

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:**	05/29/2024
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health and Human Services, Integrated Healthcare..
R414-31. Inpatient Psychiatric Services for Individuals Under 21 Years of Age.
R414-31-1. Introduction and Authority.

(1) Except for certain age groups, Medicaid excludes coverage of patients in an institution for mental disease. The state has elected to cover these inpatient psychiatric services for individuals under 21 years of age in accordance with the conditions set forth below.

(2) 42 USC 1396d(a)(16) and (h) authorizes the provision of this service under a state's Medicaid program.

R414-31-2. Client Eligibility Requirements.

Categorically and medically needy Medicaid members are eligible for this service if the service is provided before the member reaches 21 years of age or, if the member was receiving the services immediately before the member reached 21 years of age, before the earlier of:

(1) the date the member no longer requires the services; or
(2) the date the member reaches 22 years of age.

R414-31-3. Program Access Requirements.

(1) Before admission for inpatient psychiatric services or before authorization for Medicaid payment, a facility physician must make a medical evaluation of the member's need for care in the hospital and certify that inpatient services are needed.

(2) The certification must document that:

(a) ambulatory care resources available in the community do not meet the treatment needs of the member;

(b) proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(c) the services can reasonably be expected to improve the member's condition or prevent further regression so that services are no longer necessary.

(3) The Office of Licensing within the Division of Licensing and Background Checks, reviews the medical evaluation and certification and determines that the member meets certification of need requirements.

R414-31-4. Service Coverage.

(1) Services must be provided under the direction of a physician and must be based on a plan of care that includes an integrated program of therapies, activities, and experiences designed to meet the member's treatment objectives. The plan of care must be a written plan developed for each member to improve the member's condition to the extent that inpatient care is no longer necessary.

(2) At the appropriate time, the physician must develop post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the member's treatment objectives.

R414-31-5. Qualified Providers.

Inpatient psychiatric services for members under 21 years of age are provided only by the Utah State Hospital.

R414-31-6. Reimbursement for Services.

The Department pays the lower amount of costs or charges and uses Medicare regulations to define allowable costs.

KEY: Medicaid
Date of Last Change: November 10, 2023
Notice of Continuation: May 31, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-49**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
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 catchline:
R414-49. Dental, Oral, and Maxillofacial Surgeons and Orthodontia.
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26B-3-108 requires the department to implement Medicaid through administrative rules, and Section 26B-1-213 grants the department the authority to adopt, amend, or rescind these rules. Additionally, 42 CFR 440.130 authorizes preventive services for Medicaid members.
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 provides a scope of dental services for members who are eligible under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, pregnant members, blind or disabled members, aged members, members of the targeted adult Medicaid population, and members who are otherwise eligible under Medicaid and qualify for emergency dental.

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:**	05/29/2024
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health and Human Services, Integrated Healthcare.
R414-49. Dental, Oral, and Maxillofacial Surgeons and Orthodontia.
R414-49-1. Introduction.

The Medicaid Dental Program provides a scope of dental services for Medicaid members in accordance with the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Utah Medicaid State Plan, as incorporated into Section R414-1-5.

R414-49-2. Definitions.

(1) In addition to the definitions in Rule R414-1 and the Utah Medicaid Provider Manual, Section I: General

Information, the following definitions apply to this rule:

(a) "Anterior tooth" means tooth numbers:

(i) 6 through 11;

(ii) 22 through 27;

(iii) C through H; and

(iv) M through R.

(b) "Dental services" whether furnished in the office, a hospital, a skilled nursing facility, or elsewhere, means covered services performed within the scope of the Medicaid-enrolled dental provider's license as defined in Title 58, Occupations and Professions.

(c) "Posterior tooth" means tooth numbers:

(i) 1 through 5;

(ii) 12 through 21;

(iii) 28 through 32;

(iv) A through B;

(v) I through L; and

(vi) S through T.

R414-49-3. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

This section defines the scope of dental services available to members who are eligible under the EPSDT program, and includes comprehensive and preventive health care services.

(1) The following program access requirement applies.

(a) Dental services are available only through an enrolled dental provider that complies with relevant laws and policy.

(2) The following coverage and limitations apply.

(a) Dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid.

(b) Dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions.

(c) Additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual. These limitations and exclusions are updated in the Medicaid Information Bulletin.

(d) Medicaid reimburses one evaluation for one member each day, even if more than one provider is involved from the same office or clinic. Medicaid does not cover multiple exams for the same date of service.

(e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture.

(f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove the remaining third molars during the same procedure.

(g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments.

(h) The laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services.

(3) Medicaid does not cover the following types of dental services:

(a) cast crowns, porcelain fused to metal, on posterior permanent teeth or on primary teeth;

(b) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;

(c) fixed bridges or pontics;

(d) all types of dental implants;

(e) tooth transplantation;

(f) ridge augmentation;

(g) osteotomies;

(h) vestibuloplasty;

(i) alveoloplasty;

(j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;

(k) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;

(l) procedures such as arthrostomy, meniscectomy, or condylectomy;

(m) nitrous oxide analgesia;

(n) house calls;

(o) consultation or second opinions not requested by Medicaid;

(p) services provided without prior authorization;

(q) general anesthesia for removal of an erupted tooth;

(r) oral sedation for behavior management;

(s) temporary dentures or temporary stayplate partial dentures;

(t) limited orthodontic treatment, including removable appliance therapies;

(u) removable appliances in conjunction with fixed banded treatment; and

(v) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.

(4) The following dental spend-ups apply.

(a) A Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes the responsibility for the difference in fees for the following dental procedures:

(i) covered anterior stainless steel crowns that are deciduous, to non-covered anterior stainless steel crowns with composite facings added or commercial or lab-prepared facings.

R414-49-4. Pregnant Members.

This section defines the scope of dental services available to pregnant members who are eligible for Traditional Medicaid. Dental services extend for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60 days lapse.

(1) The following program access requirement applies.

(a) Dental services are available only through an enrolled dental provider that complies with relevant laws and policy.

(2) The following coverage and limitations apply.

(a) Dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid.

(b) Dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions.

(c) Additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual. These limitations and exclusions are updated in the Medicaid Information Bulletin.

(d) Medicaid reimburses one evaluation for one member each day, even if more than one provider is involved from the same office or clinic. Medicaid does not cover multiple exams for the same date of service.

(e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture.

(f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove the remaining third molars during the same procedure.

(g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments.

(h) The laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services.

(3) Medicaid does not cover the following types of dental services:

(a) cast crowns, porcelain fused to metal, on posterior permanent teeth or on primary teeth;

(b) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;

(c) fixed bridges or pontics;

(d) all types of dental implants;

(e) tooth transplantation;

(f) ridge augmentation;

(g) osteotomies;

(h) vestibuloplasty;

(i) alveoloplasty;

(j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;

(k) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;

(l) procedures such as arthrostomy, meniscectomy, or condylectomy;

(m) nitrous oxide analgesia;

(n) house calls;

(o) consultation or second opinions not requested by Medicaid;

(p) services provided without prior authorization;

(q) general anesthesia for removal of an erupted tooth;

(r) oral sedation for behavior management;

(s) temporary dentures or temporary stayplate partial dentures;

(t) limited orthodontic treatment, including removable appliance therapies;

(u) removable appliances in conjunction with fixed banded treatment; and

(v) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.

(4) The following dental spend-ups apply.

(a) A Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes the responsibility for the difference in fees for the following dental procedure:

(i) covered anterior stainless steel crowns that are deciduous, to non-covered anterior stainless steel crowns with composite facings added or commercial or lab-prepared facings.

R414-49-5. Blind or Disabled Members.

This section defines the scope of dental services available to blind or disabled members eligible for Traditional Medicaid who are 18 years of age or older, as defined in Subsection 1614(a) of the Social Security Act. Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services, and allowed under

Section 1115 of the Social Security Act.

(1) The following program access requirements apply.

(a) Dental services are available only through an enrolled dental provider that complies with relevant laws and policy.

(b) A dental provider may only perform services to this population through the University of Utah School of Dentistry (SOD) and its associated in-state provider network.

(2) The following coverage and limitations apply:

(a) dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid;

(b) dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions;

(c) additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual, and are updated in the Medicaid Information Bulletin;

(d) Medicaid reimburses one evaluation for one member each day, even if more than one provider is involved from the same office or clinic, not multiple exams for the same date of service;

(e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture;

(f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction, and by discretion, a provider may remove the remaining third molars during the same procedure;

(g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments; and

(h) a laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services.

(3) Medicaid does not cover the following types of dental services:

(a) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;

(b) fixed bridges or pontics;

(c) all types of dental implants;

(d) tooth transplantation;

(e) ridge augmentation;

(f) osteotomies;

(g) vestibuloplasty;

(h) alveoloplasty;

(i) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;

(j) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;

(k) procedures such as arthrostomy, meniscectomy, or condylectomy;

(l) nitrous oxide analgesia;

(m) house calls;

(n) consultation or second opinions not requested by Medicaid;

(o) services provided without prior authorization;

(p) general anesthesia for removal of an erupted tooth;

(q) oral sedation for behavior management;

(r) temporary dentures or temporary stayplate partial dentures;

(s) limited orthodontic treatment, including removable appliance therapies;

(t) removable appliances in conjunction with fixed banded treatment; and

(u) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.

R414-49-6. Targeted Adult Medicaid (TAM).

This section defines the scope of dental services available to eligible targeted adult Medicaid members who are actively receiving treatment in a substance abuse treatment program as defined in Section 26B-2-101, licensed under Title 26B, Chapter 2, Licensure of Programs and Facilities. Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services, and allowed under Section 1115 of the Social Security Act.

(1) The following program access requirements apply.

(a) Dental services are available only through an enrolled dental provider that complies with relevant laws and policy.

(b) A dental provider may only perform services to this population through the SOD and its associated in-state provider network.

(c) Before performing any dental services, SOD shall obtain verification of active treatment for substance use disorder (SUD) from the substance abuse treatment program. The SOD shall then submit an SUD verification form to Medicaid for each eligible TAM member. The SUD verification form is available in "All Providers General Attachments" on the Utah Medicaid website at https://medicaid.utah.gov.

(2) The following coverage and limitations apply:

(a) dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid;

(b) dental services are subject to limitations and exclusions of medical necessity and utilization control considerations

or conditions;

(c) additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual, and are updated in the Medicaid Information Bulletin;

(d) Medicaid reimburses one evaluation for one member each day, even if more than one provider is involved from the same office or clinic, not multiple exams for the same date of service;

(e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture;

(f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction, and by discretion, a provider may remove the remaining third molars during the same procedure;

(g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments;

(h) a laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services; and

(i) Medicaid covers porcelain crowns and cast crowns. Cast crowns are porcelain fused to metal.

(3) Medicaid does not cover the following types of dental services:

(a) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;

(b) fixed bridges or pontics;

(c) all types of dental implants;

(d) tooth transplantation;

(e) ridge augmentation;

(f) osteotomies;

(g) vestibuloplasty;

(h) alveoloplasty;

(i) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;

(j) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;

(k) procedures such as arthrostomy, meniscectomy, or condylectomy;

(l) nitrous oxide analgesia;

(m) house calls;

(n) consultation or second opinions not requested by Medicaid;

(o) services provided without prior authorization;

(p) general anesthesia for removal of an erupted tooth;

(q) oral sedation for behavior management;

(r) temporary dentures or temporary stayplate partial dentures;

(s) limited orthodontic treatment, including removable appliance therapies;

(t) removable appliances in conjunction with fixed banded treatment; and

(u) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.

R414-49-7. Aged Members.

This section defines the scope of dental services available to aged members eligible for Traditional Medicaid who are 65 years of age or older, as defined in 42 U.S.C Sec. 1382c(a)(1)(A). Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services, and allowed under Section 1115 of the Social Security Act.

(1) The following program access requirements apply.

(a) Dental services are available only through an enrolled dental provider that complies with relevant laws and policy.

(b) A dental provider may only perform services to this population through the SOD and its associated in-state provider network.

(2) The following coverage and limitation provisions apply:

(a) dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid;

(b) dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions;

(c) additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual, and are updated in the Medicaid Information Bulletin;

(d) Medicaid reimburses one evaluation for one member each day, even if more than one provider is involved from the same office or clinic, not multiple exams for the same date of service;

(e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture;

(f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction, and by discretion, a provider may remove the remaining third molars during the same procedure;

(g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments;

(h) a laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services;
(i) Medicaid covers porcelain crowns and cast crowns. Cast crowns are porcelain fused to metal.
(3) Medicaid does not cover the following types of dental services:
(a) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;
(b) fixed bridges or pontics;
(c) all types of dental implants;
(d) tooth transplantation;
(e) ridge augmentation;
(f) osteotomies;
(g) vestibuloplasty;
(h) alveoloplasty;
(i) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;
(j) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;
(k) procedures such as arthrostomy, meniscectomy, or condylectomy;
(l) nitrous oxide analgesia;
(m) house calls;
(n) consultation or second opinions not requested by Medicaid;
(o) services provided without prior authorization;
(p) general anesthesia for removal of an erupted tooth;
(q) oral sedation for behavior management;
(r) temporary dentures or temporary stayplate partial dentures;
(s) limited orthodontic treatment, including removable appliance therapies;
(t) removable appliances in conjunction with fixed banded treatment; and
(u) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.

R414-49-8. Emergency Dental.

This section defines the scope of dental services available to members who are otherwise eligible under the Medicaid program.

(1) The following program access requirement applies.
(a) Dental services are available only through an enrolled dental provider that complies with relevant laws and policy.
(2) The following coverage and limitations apply.
(a) Emergency dental services are the treatment of a sudden and acute onset of a dental condition that requires immediate treatment, when delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.
(b) Emergency dental service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual. These limitations and exclusions are updated in the Medicaid Information Bulletin.

KEY: Medicaid
Date of Last Change: November 10, 2023
Notice of Continuation: May 31, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-502**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
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 catchline:
R414-502. Nursing Facility Levels of Care.
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26B-3-108 requires the department to implement Medicaid through administrative rules, and Section 26B-1-213 grants the department the authority to adopt, amend, or rescind these rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The department will continue this rule because it defines the levels of care that nursing facilities may provide for Medicaid members.

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:**	05/29/2024
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

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

(1) This rule defines the levels of care provided in nursing facilities.
(2) Sections 26B-1-213 and 26B-3-108 authorize this rule.

R414-502-2. Definitions.

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

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

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

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

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

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

(2) The Department shall determine whether at least two of the factors described in Subsection (1) exist by reviewing the following clinical documentation:

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

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

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

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

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

(f) documentation indicating that less restrictive alternatives or services to prevent or defer nursing facility care have been explored.

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

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

(a) is COVID-19 positive;

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

(c) is admitting directly from:

(i) a licensed, assisted living facility;

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

(iii) an acute care, inpatient hospital.

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

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

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

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

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

(2) The following routine-skilled care does not qualify as intensive-skilled care in making a determination under this section:

(a) skilled nursing services described in 42 CFR 409.33(b);

(b) skilled rehabilitation services described in 42 CFR 409.33(c);

(c) routine monitoring of medical gases after a therapy regimen;

(d) routine enteral tube and gastronomy feedings; and

(e) routine isolation room and techniques.

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

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

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

(a) there is no reasonable expectation that the applicant will benefit further from any care and services available in an acute care hospital that are not available in a nursing facility, or the applicant's condition requires physician follow-up at the nursing facility at least once every 30 days;

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

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

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

nursing facility.

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

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

(a) a complication occurs that involves the condition for which the applicant was originally approved for intensiveskilled care; and

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

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

For the Department to authorize Medicaid coverage for the Behaviorally Complex Program, a nursing facility must:

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

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

(b) the resident engages in verbally abusive behavior where the resident threatens, screams, or curses at others;

(c) the resident presents a threat of hitting, shoving, scratching, or sexually abusing other residents; or

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

(i) makes disruptive sounds, noises, and screams;

(ii) engages in self-abusive acts;

(iii) engages in inappropriate sexual behavior;

(iv) disrobes in public;

(v) smears or throws food or feces;

(vi) hoards; and

(vii) rummages through others belongings.

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

(f) the resident's behavior interferes significantly with the stability of the living environment and interferes with other residents' ability to participate in activities or engage in social interactions; and

(2) demonstrate that an appropriate behavioral intervention program has been developed for the resident as follows:

(a) behavior intervention programs shall:

(b) plan the systematic application of methods and experimental findings of behavioral science with the intent to reduce observable negative behaviors;

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

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

(e) incorporate a process for identifying and reinforcing a desirable replacement behavior;

(f) include a program data sheet; and

(g) include a behavior baseline profile that consists of the following:

(i) include the applicant name;

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

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

(iv) demonstrate interventions for the undesirable behavior and their results; and

(v) provide recommendations for future action; and

(h) the interdisciplinary team shall include a behavior intervention plan that consists of the following:

(i) the applicant's name, the date the plan is prepared, and when the plan will be used;

(ii) the objectives stated in terms of specific behaviors;

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

(iv) the methods and frequency of data collection and review.

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

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

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

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

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

(4) the nursing facility must document the need for specialized rehabilitative services in the resident's comprehensive plan of care.

(5) Specialized rehabilitative services may include:

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

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

(c) development, maintenance, and implementation of programs designed to teach individuals daily living skills that may include:

(i) grooming and personal hygiene;

(ii) mobility;

(iii) nutrition, health, and self-feeding;

(iv) medication management;

(v) mental health education;

(vi) money management;

(vii) maintenance of the living environment;

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

(d) formal behavior modification programs; and

(e) development of appropriate-person support networks.

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

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

(1) The individual must have a diagnosis of:

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

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

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

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

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

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

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

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

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

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

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

(4) To meet the criteria of a condition closely related to an intellectual disability, an individual must manifest the condition before the individual turns 22 years of age and the condition must be likely to continue. The following criteria further specify the Department's consideration of a closely related condition.

(a) The Department does not require an individual to demonstrate an intellectual impairment of cerebral palsy, but the individual must demonstrate functional limitations as described in Subsection (2).

(b) The Department does not require an individual to demonstrate an intellectual impairment of epilepsy, but the individual must demonstrate functional limitations as described in Subsection (2).

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

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

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

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

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

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

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

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

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

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

(b) Symptoms must be present in early childhood.

(c) Symptoms must together limit and impair everyday functioning.

(d) An individual must have a severe brain injury that is the result of an acquired brain injury, traumatic brain injury, stroke, anoxia, or meningitis.

(e) An individual must have a diagnosis of fetal alcohol syndrome.

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

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

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

(a) learning disability;

(b) behavior or conduct disorders;

(c) substance abuse;

(d) hearing or vision impairment;

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

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

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

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

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

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

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

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

KEY: Medicaid
Date of Last Change: October 30, 2023
Notice of Continuation: May 31, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-503**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
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 catchline:
R414-503. Preadmission Screening and Resident Review.
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26B-3-108 requires the department to implement Medicaid through administrative rules, and Section 26B-1-213 grants the department the authority to adopt, amend, or rescind these rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The department will continue this rule because it implements the required preadmission screening and resident review of nursing facility residents with serious mental illness or intellectual disability.

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:**	05/29/2024
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-503. Preadmission Screening and Resident Review.
R414-503-1. Introduction and Authority.

This rule implements 42 U.S.C. 1396r(b)(3) and (e)(7) and Pub. L. No. 104 315, which require preadmission screening and resident review (PASRR) of nursing facility residents with serious mental illness or intellectual disability. This rule applies to all Medicare and Medicaid-certified nursing facility admissions irrespective of the payment source of an individual's nursing facility services.

R414-503-2. Definitions.

In addition to the definitions in Section R414-1-2 and Section R414-501-2, the following definitions apply:
(1) "Break in stay" occurs when a resident of a Medicare and Medicaid-certified nursing facility:
(a) voluntarily leaves against medical advice for more than two consecutive days;

(b) fails to return within two consecutive days after an authorized leave of absence;
(c) discharges into a community setting; or
(d) is admitted to the Utah State Hospital, to a civil or forensic bed, but not the Adult Recovery Treatment Center.
(2) "Intellectual disability" is the equivalent term for mental retardation under federal law.

R414-503-3. PASRR Level I Screening for All Persons.

(1) The purpose of a PASRR Level I screening is for a health care professional to identify any person with a serious mental illness, intellectual disability, or other related condition so the professional may consider that person for admission to a Medicare and Medicaid-certified nursing facility. The health care professional who conducts the Level I screening shall refer the person for a Level II evaluation if the professional determines the person has a serious mental illness, intellectual disability, or other related condition.

(2) The health care professional shall complete a Level I screening before any Medicare and Medicaid-certified nursing facility admission.

(3) The health care professional shall complete the Level I screening on a form supplied by the Department.

(4) The health care professional shall sign and date the Level I screening.

(5) The nursing facility shall revise the Level I screening if there is a significant change in the person's condition.

(6) The Department shall require Level I screening for all persons even if a person cannot cooperate or participate in Level I screening due to delirium or other emergency circumstances. The health care professional shall complete the Level I screening by using available medical information or other outside information.

R414-503-4. PASRR Level II Evaluation Criteria.

(1) The purpose of a Level II evaluation is to avoid unnecessary or inappropriate nursing facility admission of persons with serious mental illness or intellectual disabilities or related conditions. The Level II evaluation ensures that persons with serious mental illness or intellectual disabilities or related conditions are recommended for specialized services when a health care professional determines there is a need for specialized services during the evaluation process. The Department bases Level II evaluations on the criteria set forth in 42 CFR 483.130. Level II evaluations must address the level of nursing services, specialized services, and specialized rehabilitative services needed for the patient.

(2) The health care professional who completes the Level I screening shall refer the person to a contracted mental health PASRR Evaluator for the Level II evaluation if the Level I screening indicates the person meets all of the following criteria:

(a) the person has a serious mental illness as defined by the State Mental Health Authority and identified by the Level I screening;

(b) the diagnosis of mental illness falls within the diagnostic groupings as described in the Diagnostic and Statistical Manual; and

(c) in addition to the criteria listed in Subsection (2)(a)(b), the person meets any one of the following criteria:

(i) the person has undergone psychiatric treatment at least twice in the last two years that is more intensive than outpatient care;

(ii) due to a significant disruption in the person's normal living situation, the person requires supportive services to maintain the current level of functioning at home or in a residential treatment center; or

(iii) the person requires intervention by housing or law enforcement officials.

(3) The health care professional who completes the Level I screening shall refer the person to the Intellectual Disability or Related Condition Authority for the Level II evaluation if the Level I screening indicates the person meets at least one of the following criteria:

(a) the person has received a diagnosis of an intellectual disability or related condition;

(b) the person has received a diagnosis of epilepsy or seizure disorder with onset before 22 years of age;

(c) the person has a history of intellectual disability or related condition, or an indication of cognitive or behavioral patterns that indicate the person has an intellectual disability or related condition; or

(d) the person is referred by any agency that specializes in the care of persons with intellectual disabilities or related conditions.

(4) The health care professional who completes the Level I screening shall refer the person to both the contracted mental health PASRR Evaluator and the Intellectual Disability or Related Condition Authority if the person meets the criteria for Subsection (2) and (3).

(5) The health care professional who completes the Level I screening shall provide written notice of a Level II evaluation referral to the person, the person's legal representative, and the prospective nursing facility.

(6) If the person does not meet the criteria in Subsection (2) or (3), the Department may not require a further PASRR Evaluation unless there is a significant change in condition.

R414-503-5. PASRR Level II Exemptions.

The Department may not require a Level II evaluation for any of the following reasons:

(1) The person does not meet the criteria listed in Subsection R414-503-4(2) or (3).

(2) The nursing facility admits the person as a provisional admission due to delirium, an accurate diagnosis cannot be made until the delirium clears, and the nursing facility placement does not exceed seven days. The nursing facility shall refer the

person for a Level II evaluation before midnight on the seventh day if the placement will extend beyond the seventh day.

(3) The nursing facility admits the person as a provisional admission due to an emergency situation requiring protective services, and the nursing facility placement does not exceed seven days. The nursing facility shall refer the person for a Level II evaluation before midnight on the seventh day if the placement will extend beyond the seventh day.

(4) The person is admitted to a nursing facility directly from a hospital and requires nursing facility services for the condition treated in the hospital, not psychiatric treatment, and the attending physician certifies in writing before the admission that the person is likely to be discharged in less than 30 days. The nursing facility shall refer the person for a Level II evaluation before midnight on the 30th day if the placement will extend beyond the 30th day.

(5) The contracted mental health PASRR evaluator may terminate the Level II evaluation at any time if the evaluator determines the person does not have a serious mental illness. The Level II evaluator shall document that the person does not have a serious mental illness.

(6) The person has a previous Level II evaluation and the nursing facility readmits the person to the same or a different nursing facility following hospitalization for medical care without a break in stay. This provision does not apply if the person is hospitalized for acute psychiatric treatment. Following readmission, the nursing facility shall review and update the PASRR Level I Screening to determine whether there is a significant change in condition that requires a Level II re-evaluation.

(7) The person has a previous Level II evaluation and the nursing facility transfers the person to another nursing facility with or without intervening hospitalization and without a break in stay. This provision does not apply if the person is hospitalized for psychiatric treatment. Following transfer, the nursing facility shall review and update the Level I screening to determine whether there is a significant change in condition that requires a Level II re-evaluation.

R414-503-6. PASRR Level II Categorical Determinations.

The Level II evaluator may make one of the following categorical determinations.

(1) The person is eligible for convalescent care for an acute physical illness that requires hospitalization and does not meet the criteria for an exempt hospital discharge, which, as specified in 42 CFR 483.106(b)(2), is not subject to preadmission screening. The convalescent care determination applies only if the person is at a hospital for a medical condition and is going to the Medicare and Medicaid-certified nursing facility for the same medical condition. The convalescent care categorical determination is valid for up to 120 days. The nursing facility shall refer the person for a Level II evaluation before midnight on the 120th day if the placement will extend beyond the 120th day.

(2) The person is eligible for a short-term stay for an acute physical illness in which the person is seeking admission to the nursing facility directly from a community setting. The short-term stay categorical determination is valid for a maximum of 120 days. The nursing facility shall refer the person for a Level II evaluation before the end of the number of days specified if the placement will extend beyond the number of days specified by the State Mental Health Authority or Intellectual Disabilities Authority.

(3) The person is eligible for a stay related to a terminal illness when a physician provides a written statement that the person has a terminal illness. If the individual is not receiving hospice services at the time of the Level II evaluation, an individualized Level II evaluation is required.

(4) The person is eligible for a severe physical illness categorical determination when the person has a level of impairment so severe that the individual cannot be expected to benefit from specialized services. This level of impairment includes conditions such as:

(a) being in a coma;

(b) being ventilator dependent; or

(c) functioning at a brain stem level.

(5) The State Intellectual Disability Authority or delegated agency, not Level I screeners, may make categorical determinations that individuals with dementia, which exists in combination with intellectual disability or a related condition, do not need specialized services.

(6) The health care professional may terminate the PASRR Level II evaluation if the health care professional discovers that the person has dementia and a serious mental illness during the evaluation process, and there is evidence that dementia is the primary condition. For example, the dementia has resulted in increased functional deficits and is the primary reason for requiring nursing facility services.

R414-503-7. Individualized Level II Determinations.

The Level II evaluator may make one of the following individualized determinations.

(1) The person does not need nursing facility services. This determination disqualifies the person from admission to a Medicare and Medicaid-certified nursing facility.

(2) The person does not need nursing facility services, but does need specialized services as defined by the State Mental Health Authority or Intellectual Disability or Related Condition Authority. This determination disqualifies the person from admission to a Medicare and Medicaid- certified nursing facility.

(3) The person needs nursing facility services, but not specialized services. This determination qualifies the person for admission to a Medicare and Medicaid-certified nursing facility.

(4) The person needs nursing facility services and requires specialized services. The Level II evaluation will specify the needed specialized services. This determination qualifies the person for admission to a Medicare and Medicaid-certified nursing facility. The State Mental Health Authority or the Intellectual Disabilities or Related Conditions Authority shall provide

a copy of the Level II evaluation and findings to the person, the person's legal representative, the nursing facility, and the attending physician.

(5) If a person requires an out-of-state arrangement for payment, then the state in which a person is a resident at the time the person becomes eligible for Medicaid, shall pay for the Level II evaluation. Out-of-state payment arrangements are defined in 42 CFR 435.403 and 42 CFR 431.52(b).

(6) The nursing facility, in consultation with the person and his legal representative, shall arrange for a safe and orderly discharge from the nursing facility, and shall assist with linking the person to supportive services and preparing the person for discharge if the person no longer meets the medical criteria for nursing facility services, or a Level II evaluation disqualifies the person as no longer eligible for nursing facility placement.

R414-503-8. Penalties.

A nursing facility may not admit a patient until the health care professional completes the PASRR Level I Screening, and if necessary, the PASRR Level II evaluation and determination, finding that the patient is eligible for nursing facility services. The Department may not reimburse a nursing facility for any days in which the facility admits a patient before completion of the PASRR process.

KEY: Medicaid
Date of Last Change: August 17, 2023
Notice of Continuation: May 31, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-36**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

R414-36. Rehabilitative Mental Health and Substance Use Disorder Services.

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

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

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

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

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

The department will continue this rule because it implements rehabilitative mental health and substance use disorder services as described in the Medicaid provider manual and in the Medicaid State Plan.

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:**	06/04/2024

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

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-36. Rehabilitative Mental Health and Substance Use Disorder Services.
R414-36-1. Introduction.

Rehabilitative mental health and substance use disorder services may be provided to Medicaid recipients in accordance with the Rehabilitative Mental Health and Substance Use Disorder Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.

KEY: Medicaid
Date of Last Change: November 10, 2023
Notice of Continuation: June 5, 2019
Authorizing, and Implemented or Interpreted Law: 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-140**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

R414-140. Choice of Healthcare Delivery Program.

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

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

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

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

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

The department will continue this rule because it sets forth requirements and coverage for Medicaid members under the Choice of Healthcare Delivery 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:**	06/04/2024

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.

R414-140. Choice of Health Care Delivery Program.

R414-140-1. Introduction and Authority.

This rule outlines the Choice of Health Care Delivery Program that operates under a freedom-of-choice waiver program authorized under 42 USC 1396n(b). This program provides access to quality and cost-effective health care. This rule is required by Utah Code Subsection 26-18-3(2)(a).

R414-140-2. Definitions.

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

(1) The "Choice of Health Care Delivery Program" (CHCDP) is a freedom-of-choice waiver program that allows the Department to require certain groups of Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to select a health plan that provides services in accordance with the program's waiver. The waiver limits freedom of choice in choosing a health care provider.

(2) An "Enrollee" in the CHCDP is a Medicaid client who lives in an urban county and is enrolled in a health plan.

(3) A "Health Plan" in the CHCDP is a federally defined prepaid inpatient health plan, a federally defined primary care case management system or a federally defined managed care organization under contract with the Utah Department of Health to provide health care services to enrollees.

(4) A "Managed Care Organization" (MCO) is an entity that has a comprehensive risk contract with the Department to make the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid clients within the area served by the entity. The CHCDP requires MCOs to provide or arrange for services described in the CHCDP.

(5) "Prepaid Inpatient Health Plan" (PIHP) is an entity that contracts with the Department under a non-risk arrangement to provide services described in the CHCDP to Medicaid enrollees.

(6) "Primary Care Case Management" (PCCM) is a system under which a physician or other provider contracts with the State to furnish case management services and to provide access to services described in the CHCDP.

(7) "Section 1931" is the section of the Social Security Act that raises the income limits for Medicaid eligibility.

(8) "Urban county" means a county with a population greater than 175,000.

(9) "1115 Demonstration for the Primary Care Network of Utah" is a statewide demonstration waiver that expands Medicaid coverage to adults ages 19 and older who would not otherwise qualify for Medicaid. The two groups of individuals covered under the 1115 Demonstration are Primary Care Network individuals and Non-Traditional Medicaid individuals. Primary Care Network individuals are those who meet certain income requirements who would not otherwise qualify for Medicaid. Non-Traditional Medicaid individuals are those who are ages 19 and older and are not elderly, disabled or pregnant.

R414-140-3. Requirement to Select a Health Plan.

(1) The following Medicaid clients living in urban counties are required to select a health plan:

(a) Section 1931 children under the age of 19;

(b) pregnant women;

(c) blind or disabled children and adults;

(d) aged populations;

(e) foster care children; and

(f) Non-Traditional Medicaid enrollees covered under the 1115 Demonstration for the Primary Care Network of Utah.

R414-140-4. Restrictions on Changes in Enrollment.

(1) The Department must give Medicaid clients a choice of at least two health plans. Each new applicant for Medicaid in the urban counties is offered an orientation about Medicaid and the Choice of Health Care Delivery Program. A health program representative employed by the Department conducts the orientation and also enrolls Medicaid clients in a health plan. During the orientation the clients are presented with health plan options.

(2) The Department restricts the disenrollment rights of enrollees who are required to enroll with a health plan in accordance with the regulations at 42 CFR 438.56. Disenrollment rights are restricted for a period of up to 12 months with the following exceptions:

(a) during the first three months of the enrollee's initial enrollment with a health plan, the enrollee may select a different health plan without cause;

(i) if the enrollee moves out of the health plan's service area;

(ii) if the enrollee requests to select a different health plan for good cause and the Department approves the request; or

(iii) if the enrollee chooses a different health plan during the Department's annual disenrollment period.

R414-140-5. Service Coverage.

(1) Health plans shall provide all medically necessary services covered under the State Medicaid Plan except:

(a) dental services;

(b) chiropractic services;

(c) long term care services in skilled nursing facilities longer than 30 days with the exception of clients enrolled in the Medicaid Long Term Care Managed Care Program;

(d) psychological services;

(e) services covered under the Prepaid Mental Health Plan;

(f) substance abuse treatment services; and

(g) transportation services;

(2) Medicaid enrollees who are covered under the Non-Traditional Medicaid Plan are limited to the scope of services as defined in the 1115 Demonstration for the Primary Care Network of Utah.

R414-140-6. Qualified Providers.

The Department selects managed care organizations, prepaid inpatient health plans or primary care case management systems through an open cooperative procurement process in which any qualifying MCO, PIHP or PCCM system may request to contract with the Department to provide services covered under the CHCDP.

R414-140-7. Reimbursement Methodology.

The PIHPs are paid under a non-risk arrangement as described in 42 CFR 447.362. The Department's payments to the health plans may not exceed what the Department would have paid on a fee-for service basis for services furnished to health plan enrollees plus the net savings of administrative costs the Department achieves by contracting with the health plans instead of purchasing the services on a fee-for-service basis. The PCCM providers are paid under a fee-for-service arrangement. In addition, a fee is paid to cover the provision of case management services.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: September 16, 2004
Notice of Continuation: June 5, 2019
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-501**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

R414-501. Preadmission Authorization, Retroactive Authorization, and Continued Stay Review.

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

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

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

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

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

The department will continue this rule because it implements nursing facility and utilization requirements for continued stays in nursing facilities.

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:**	06/04/2024

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.
R414-501. Preadmission Authorization, Retroactive Authorization, and Continued Stay Review.
R414-501-1. Introduction and Authority.

This rule implements the nursing facility and utilization requirements of 42 U.S.C. Sec. 1396r(b)(3), (e)(5), and (f)(6)(B), 42 CFR 456.1 through 456.23, and 456.350 through 456.380, by requiring the evaluation of each resident's need for admission and continued stay in a nursing facility. It also implements the requirements for states and long term care facilities found in 42 CFR 483.

R414-501-2. Definitions.

In addition to the definitions in Section R414-1-1, the following definitions apply to Rules R414-501 through R414-503:

(1) "Activities of daily living" are defined in 42 CFR 483.25(a)(1), and further includes adaptation to the use of assistive devices and prostheses intended to provide the greatest degree of independent functioning.

(2) "Categorical determination" means a determination made pursuant to 42 CFR 483.130 and ATTACHMENT 4.39-A of the State

Plan.

(3) "Code of Federal Regulations (CFR)" means the most current edition unless otherwise noted.

(4) "Continued stay review" means a periodic, supplemental, or interim review of a resident performed by a Department health care professional either by telephone or on-site review.

(5) "Discharge planning" means planning that ensures that the resident has an individualized planned program of post-discharge continuing care that:

(a) states the medical, functional, behavioral and social levels necessary for the resident to be discharged to a less restrictive setting;

(b) includes the steps needed to move the resident to a less restrictive setting;

(c) establishes the feasibility of the resident's achieving the levels necessary for discharge; and

(d) states the anticipated time frame for that achievement.

(6) "Health care professional" means a duly licensed or certified physician, physician assistant, nurse practitioner, physical therapist, speech therapist, occupational therapist, registered professional nurse, licensed practical nurse, social worker, or qualified mental retardation professional.

(7) "Medicaid resident" means a resident who is a Medicaid recipient.

(8) "Medicaid admission date" means the date the nursing facility requests Medicaid reimbursement to begin.

(9) "Mental retardation" is defined in 42 CFR 483.102(b)(3) and includes "persons with related conditions" as defined in 42 CFR 435.1009.

(10) "Minimum Data Set (MDS)" means the standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicare or Medicaid certified long-term care facility.

(11) "Nursing facility" is defined in 42 USC. 1396r(a), and also includes an intermediate care facility for people with mental retardation as defined in 42 USC 1396d(d).

(12) "Nursing facility applicant" is an individual for whom the nursing facility is seeking Medicaid payment.

(13) "Preadmission Screening and Resident Review (PASRR) Level I Screening" means the preadmission identification screening described in Section R414-503-3.

(14) "Preadmission Screening and Resident Review (PASRR) Level II Evaluation" means the preadmission evaluation and resident review for serious mental illness or mental retardation described in Section R414-503-4.

(15) "Physician Certification" is a written statement from the Medicaid resident's physician that certifies the individual requires nursing facility services.

(16) "Resident" means a person residing in a Medicaid-certified nursing facility.

(17) "Serious mental illness" is defined by the State Mental Health Authority.

(18) "Significant change" means a major change in the resident's physical, mental, or psychosocial status that is not self-limiting, impacts on more than one area of the resident's health status, and requires interdisciplinary review, revision of the care plan, or may require a referral to a preadmission screening resident review if a mental illness or intellectual disability or related condition is suspected or present.

(19) "Skilled care" means those services defined in 42 CFR 409.32.

(20) "Specialized rehabilitative services" means those services provided pursuant to 42 CFR 483.45 and Section R432-150-23.

(21) "Specialized services" means those services provided pursuant to 42 CFR 483.120 and ATTACHMENT 4.39 of the State Plan.

(22) "United States Code (USC)" means the most current edition unless otherwise noted.

(23) "Working days" means all work days as defined by the Utah Department of Human Resource Management.

R414-501-3. Preadmission Authorization.

(1) A nursing facility will perform a preadmission assessment when admitting a nursing facility applicant. Preadmission authorization is not transferable from one nursing facility to another.

(2) A nursing facility must obtain approval from the Department when admitting a nursing facility applicant. The nursing facility must submit a request for prior approval to the Department no later than the next business day after the date of admission. A request for prior approval may be in writing or by telephone and will include:

(a) the name, age, and Medicaid eligibility of the nursing facility applicant;

(b) the date of transfer or admission to the nursing facility;

(c) the reason for acute care inpatient hospitalization or emergency placement, if any;

(d) a description of the care and services needed;

(e) the nursing facility applicant's current functional and mental status;

(f) the established diagnoses;

(g) the medications and treatments currently ordered for the nursing facility applicant;

(h) a description of the nursing facility applicant's discharge potential;

(i) the name of the hospital discharge planner or nursing facility employee who is requesting the prior approval;

(j) the Preadmission Screening and Resident Review (PASRR) Level I screening, except the screening is not required for admission to an intermediate care facility for people with mental retardation; and

(k) the Preadmission Screening and Resident Review (PASRR) Level II determination, as required by 42 CFR 483.112.

(4) If the Department gives a telephone prior approval, the nursing facility will submit to the Department within five working days a preadmission transmittal for the nursing facility applicant, and will begin preparing the complete contact for the nursing facility applicant.

The complete contact is a written application containing all the elements of a request for prior authorization plus:

(a) the preadmission continued stay transmittal;

(b) a history and physical;

(c) the signed and dated physician's orders, including physician certification; and

(d) an MDS assessment completed no later than 14 calendar days after the resident is admitted to a nursing facility.

(5) The requirements in Section R414-501-3 do not apply in cases in which a facility is seeking Retroactive Authorization described in Section R414-501-5.

R414-501-4. Immediate Placement Authorization.

(1) The Department will reimburse a nursing facility for five days if the Department gives telephone prior approval for a resident who is an immediate placement.

(a) An immediate placement will meet one of the following criteria:

(i) The resident exhausted acute care benefits or was discharged by a hospital;

(ii) A Medicare fiscal intermediary changed the resident's level of care, or the Medicare benefit days terminated and there is a need for continuing services reimbursed under Medicaid;

(iii) Protective services in the Department of Human Services placed the resident for care;

(iv) A tragedy, such as fire or flood, has occurred in the home, and the resident is injured, or an accident leaves a dependent person in imminent danger and requires immediate institutionalization;

(v) A family member who has been providing care to the resident dies or suddenly becomes ill;

(vi) A nursing facility terminated services, either through an adverse certification action or closure of the facility, and the resident must be transferred to meet his medical or habilitation needs; or

(vii) A disaster or other emergency as defined by the Department has occurred.

(b) The Department will deny an immediate placement unless the PASRR Level I screening is completed and the Department determines a PASRR Level II evaluation is not required, or if the PASRR Level II evaluation is required, then the PASRR Level II evaluation is completed and the Department determines the nursing facility applicant qualifies for placement in a nursing facility. The two exceptions to this requirement are when the nursing facility applicant is a provisional placement for less than seven days or when the placement is after an acute hospital admission and the physician certifies in writing that the placement will be for less than 30 days.

(c) Telephone prior approval for an immediate placement will be effective for no more than five working days. During that period the nursing facility will submit a preadmission transmittal, and will begin preparing the complete contact for the nursing facility applicant. If the nursing facility fails to submit the preadmission transmittal in a timely manner, the Department will not make any payments until the Department receives the preadmission transmittal and the nursing facility complies with all preadmission requirements.

R414-501-5. Retroactive Authorization.

A nursing facility may complete a written request for Retroactive Authorization. If approved, the authorization period will begin a maximum of 90 days prior to the date the authorization request is submitted to the Department. The request for Retroactive Authorization will include documentation that will demonstrate the clinical need for nursing facility care at the time of the requested Medicaid admission date. The documentation must also demonstrate the clinical need for nursing facility care as of the current date. This documentation will allow the Department's medical professionals to determine the clinical need for nursing facility care during both the retroactive period and the current period. Documentation will include:

(a) the name of the nursing facility employee who is requesting the authorization;

(b) the Retroactive Authorization request submission date;

(c) the requested Medicaid admission date;

(d) a description of why Retroactive Authorization is being requested;

(e) the name, age, and Medicaid identification number of the nursing facility applicant;

(f) the PASRR Level I screening; except the screening is not required for admission to an intermediate care facility for people with mental retardation;

(g) the PASRR Level II determination as required by 42 CFR 483.112;

(h) a history and physical;

(i) signed and dated physician's orders, including the physician certification;

(j) MDS assessment that covers the time period for which Medicaid reimbursement is being requested; and

(k) a copy of a Medicare denial letter, a Medicaid eligibility letter, or both, as applicable.

R414-501-6. Readmission After Hospitalization.

When a Medicaid resident is admitted to a hospital, the Department will not require Preadmission Authorization when the Medicaid resident returns to the original nursing facility not later than three consecutive days after the date of discharge from the nursing facility. If the readmission occurs four or more days after the date of discharge from the nursing facility, the nursing facility will complete the Preadmission Authorization process again including revising the PASRR Level I screening to evaluate the need for a new PASRR Level II evaluation.

R414-501-7. Continued Stay Review.

(1) The Department will conduct a continued stay review to determine the need for continued stay in a nursing facility and to

determine whether the resident has shown sufficient improvement to implement discharge planning.

(2) If a question regarding placement or the ongoing need for nursing facility services for a Medicaid resident arises, the Department may request additional information from the nursing facility. If the question remains unresolved, a Department health care professional may perform a supplemental on-site review. The Department or the nursing facility can also initiate an interim review because of a change in the Medicaid resident's condition or medical needs.

(3) A nursing facility will make appropriate personnel and information reasonably accessible so the Department can conduct the continued stay review.

(4) A nursing facility will inform the Department by telephone or in writing when the needs of a Medicaid resident change to possibly require discharge or a change from the findings in the PASRR Level I screening or PASRR Level II evaluation. A nursing facility will inform the Department of newly acquired facts relating to the resident's diagnosis, medications, treatments, care or service needs, or plan of care that may not have been known when the Department determined medical need for admission or continued stay. With any significant change, the nursing facility is responsible to revise the PASRR Level I screening to evaluate the need for a new PASRR Level II evaluation.

(5) The Department will deny payment to a nursing facility for services provided to a Medicaid resident who, against medical advice, leaves a nursing facility for more than two consecutive days, or who fails to return within two consecutive days after an authorized leave of absence. A nursing facility will report all such instances to the Department. The resident will complete all preadmission requirements before the Department may approve payment for further nursing facility services.

R414-501-8. Payment Responsibility.

(1) If a nursing facility accepts a resident who elects not to apply for Medicaid coverage, and the nursing facility can prove that it gave the resident or his legal representative written notice of Medicaid eligibility and preadmission requirements, then the resident or legal representative will be solely responsible for payment for the services rendered. However, if a nursing facility cannot prove it gave the notice to a resident or his legal representative, then the nursing facility will be solely responsible for payment for the services rendered during the time when the resident was eligible for Medicaid coverage.

(2) For Preadmission Authorization requests described in Section R414-501-3, the Department will deny payment to a nursing facility for services provided:

(a) before the date of the verbal prior approval or the date postmarked on the envelope containing the written application, or the date the Department receives the written application (whichever is earliest);

(b) if the facility fails to submit a complete application by the 60th day from the date the Department receives the Preadmission Authorization request; or

(c) if the facility fails to comply with PASRR requirements.

(3) For Retroactive Authorization described in Section R414-501-5, the Department will deny payment to a nursing facility for services provided:

(a) greater than 90 days prior to the request for Retroactive Authorization;

(b) if the facility fails to submit a complete application by the 60th day from the date the Department receives the Retroactive Authorization request; or

(c) the facility fails to comply with PASRR requirements.

R414-501-9. General Provisions.

(1) The Department is solely responsible for approving or denying a Preadmission, Retroactive or continued stay authorization for payment for nursing facility services provided to a Medicaid resident. The Department is ultimately responsible for determining if a Medicaid resident has a clinical need for nursing facility services. If the Department determines a nursing facility applicant or Medicaid resident does not have a clinical need for nursing facility services, a written notice of agency action, in accordance with 42 CFR 431.200 through 431.246, 42 CFR 456.437 and 456.438 will be sent. If a nursing facility complies with all Preadmission Authorization, Retroactive Authorization and continued stay requirements for a Medicaid resident then the Department will provide coverage consistent with the State Plan.

(2) If a nursing facility fails to comply with all Preadmission Authorization, Retroactive Authorization or continued stay requirements, the Department will deny payment to the nursing facility for services provided to the nursing facility applicant. The nursing facility is liable for all expenses incurred for services provided to the nursing facility applicant on or after the date the nursing facility applicant applied for Medicaid. The nursing facility will not bill the nursing facility applicant or his legal representative for services not reimbursed by the Department due to the nursing facility's failure to follow Preadmission Authorization, Retroactive Authorization or continued stay rules.

(3) If the application is incomplete it will be denied. The Department will comply with notice and hearing requirements as defined in 42 CFR 431.200 through 431.246, and also send written notice to the nursing facility administrator, the attending physician, and, if possible, the next-of-kin or legal representative of the nursing facility applicant. If the Department denies a claim, the nursing facility can resubmit additional documentation not later than 60 calendar days after the date the Department receives the initial Preadmission or Retroactive Authorization request or continued stay transmittal. If the nursing facility fails to submit additional documentation that corrects the claim deficiencies within the 60 calendar day period, then the denial becomes final and the nursing facility waives all rights to Medicaid reimbursement from the time of admission until the Department approves a subsequent request for authorization submitted by the nursing facility.

(4) The Department adopts the standards and procedures for conducting a fair hearing set forth in 42 U.S.C. Sec. 1396a(a)(3) and 42 CFR 431.200 through 431.246, and as implemented in Rule R410-14.

R414-501-10. Safeguarding Information of Nursing Facility Applicants and Residents.

(1) The Department adopts the standards and procedures for safeguarding information of nursing facility applicants and recipients set forth in 42 U.S.C. Sec.1396a(a)(7) and 42 CFR 431.300 through 431.307.

(2) Standards for safeguarding a resident's private records are set forth in Section 63G-2-302.

R414-501-11. Free Choice of Providers.

Subject to certain restrictions outlined in 42 CFR 431.51, 42 USC 1396a(a)(23) requires that recipients have the freedom to choose a provider. A recipient who believes his freedom to choose a provider has been denied or impaired may request a hearing from the Department, as outlined in 42 CFR 431.200 through 431.221.

R414-501-12. Alternative Services Evaluation and Referral.

While reviewing a preadmission assessment for admission to a nursing care facility, other than an ICF/MR, the Department may evaluate the potential for the nursing facility applicant to receive alternative Medicaid services in a home or community-based setting that are appropriate for the needs of the individual identified in the preadmission submittals. If there appears to be a potential for alternative Medicaid services, with the permission of the nursing facility applicant, the nursing facility will refer the name of the nursing facility applicant to one or more designated Medicaid home and community-based services program representatives for follow-up contact with the nursing facility applicant.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: July 18, 2012
Notice of Continuation: June 5, 2019
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3