DMHF Rules Matrix 3-21-24

Rule Summary	Bulletin Publication	Effective
R414-310 Medicaid Primary Care Network Demonstration Waiver (Rule Repeal); The Department needs to repeal this rule as the Primary Care Network no longer exists. This rule, therefore, is repealed in its entirety	**1-1-24**	**4-1-24**
R414-504 Nursing Facility Payments; The purpose of this change is to include provisions, under a moratorium exception, for major renovation in nursing care facilities. This amendment, therefore, includes an additional definition for major renovation and specifies payment methodology and procedures.	**1-1-24**	**4-1-24**
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 is to clarify provisions for accountable care organizations (ACOs) and quality measures for hospitals in accordance with the Hospital Provider Assessment. This amendment, therefore, 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.	**4-1-24**	**5-8-24**
R414-60-7 Reimbursement (Emergency Rule); This emergency rule addresses a significant disruption to the pharmacy point of sale system affecting Medicaid users in the state. This change, therefore, allows the Medicaid division director flexibility to waive the 24-day limit on pharmacy dispensing fees under these circumstances.	**4-15-24**	**4-1-24**

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

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF PROPOSED RULE		
TYPE OF FILING: Repeal		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-310**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
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Please address questions regarding information on this notice to the persons listed above.

General Information

2. Rule or section catchline:

R414-310. Medicaid Primary Care Network Demonstration Waiver.

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

The department needs to repeal this rule as the Primary Care Network (PCN) no longer exists.

4. Summary of the new rule or change:

This rule governs PCN implementation. PCN, however, no longer exists, so the rule is repealed in its entirety.

Fiscal Information

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

A) State budget:

The Department will see neither costs nor revenue as this repeal simply removes a rule that no longer implements a non-existent program.

B) Local governments:

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

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

Small businesses will see neither costs nor revenue as this repeal simply removes a rule that no longer implements a non-existent program.

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

Non-small businesses will see neither costs nor revenue as this repeal simply removes a rule that no longer implements a non-existent program.

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

Other persons will see neither costs nor revenue as this repeal simply removes a rule that no longer implements a non-existent program.

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

There are no compliance costs as this repeal simply removes a rule that no longer implements a non-existent program.

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

Regulatory Impact Table

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

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

The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this fiscal analysis. Businesses will see neither costs nor revenue as this repeal simply removes a rule that no longer implements a non-existent program.

Citation Information

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

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

Incorporations by Reference Information

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

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

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

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

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

Public Notice Information

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

A) Comments will be accepted until:	01/31/2024

B) A public hearing (optional) will be held:

Date (mm/dd/yyyy)**:**	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**

To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.

9. This rule change MAY become effective on:	02/07/2024

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

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	12/14/2023

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

~~R414-310. Medicaid Primary Care Network Demonstration Waiver.~~

~~R414-310-1. Authority and Purpose.~~

~~(1) This rule is authorized by Sections 26-1-5 and 26-18-3. The Primary Care Network Demonstration is authorized by a waiver of federal Medicaid requirements approved by the Centers for Medicare and Medicaid Services and allowed under Section 1115(a) of the Social Security Act.~~

~~(2) The purpose of this rule is to establish eligibility requirements for enrollment under the Medicaid Primary Care Network Demonstration Waiver.~~

~~R414-310-2. Definitions.~~

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

~~(1) "Avenue H" means Utah's Health Insurance Marketplace for Utah employers and their employees where the employees can find information about available employer-sponsored health insurance plans, select a plan and enroll online.~~

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

~~(3) "Children's Health Insurance Program" or (CHIP) means the program for medical benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act.~~

~~(4) "Copayment and coinsurance" means a portion of the cost for a medical service for which the enrollee is responsible to pay for services received under the Primary Care Network.~~

~~(5) "Creditable Health Coverage" means any health insurance coverage as defined in 45 CFR 146.113.~~

~~(6) "Employer-sponsored health plan" means a health insurance plan offered by an employer either directly or through Avenue H.~~

~~(7) "Enrollee" means an individual who has applied for and has been found eligible for the Primary Care Network program.~~

~~(8) "Open enrollment" means a period during which the eligibility agency accepts applications for the Primary Care Network program.~~

~~(9) "Primary Care Network" or (PCN) means the program for benefits under the Medicaid Primary Care Network Demonstration Waiver.~~

~~(10) "Review month" means the last month of the review period for an enrollee during which the eligibility agency shall redetermine eligibility for a new review period if the enrollee completes the review process timely.~~

~~(11) "Student health insurance plan" means a health insurance plan that is offered to students directly through a university or other educational facility.~~

~~(12) "Utah's Premium Partnership for Health Insurance" or (UPP) means the program described in Rule R414-320.~~

~~R414-310-3. Applicant and Enrollee Rights and Responsibilities.~~

~~(1) The provisions of Section R414-301-4 apply to applicants and enrollees of the PCN program except that reportable changes for PCN applicants and enrollees are defined in Subsection R414-310-3(2).~~

~~(2) An applicant or enrollee must report certain changes to the eligibility agency within ten calendar days of the day the change becomes known. The eligibility agency shall notify the applicant at the time of application of the changes that the enrollee must report. Reportable changes include:~~

~~(a) An enrollee in PCN begins to receive coverage or to have access to coverage under a group health plan or other health insurance coverage;~~

~~(b) An enrollee in PCN begins to receive coverage under, or begins to have access to student health insurance, Medicare, or the Veteran's Administration Health Care System;~~

~~(c) Changes in household income;~~

~~(d) Changes in household composition;~~

~~(e) Changes in tax filing status;~~

(f) Changes in the number of dependents claimed as tax dependents;
(g) An enrollee or the household moves out of state;
(h) Change of address of an enrollee or the household; or
(i) An enrollee enters a public institution or an institution for mental diseases.
(3) An applicant or enrollee has a right to request an agency conference or a fair hearing as described in Sections R414-301-6 and R414-301-7.
(4) An enrollee in PCN is responsible for paying any required copayments or coinsurance amounts to providers for medical services that the enrollee receives that are covered under PCN.

R414-310-4. General Eligibility Requirements.
(1) The provisions of Sections R414-302-3, R414-302-4, R414-302-7, and R414-302-8 concerning United States (U.S.) citizenship, alien status, state residency, use of social security numbers, and applying for other benefits, apply to applicants and enrollees of PCN.
(2) An individual who is not a U.S. citizen or national, or who does not meet the alien status requirements of Section R414-302-3 is not eligible for any services or benefits under PCN.
(3) An individual must be at least 19 and not yet 65 years of age to enroll in PCN.
(a) The month in which an individual turns 19 years of age is the first month that the person may enroll in PCN.
(b) An individual must apply for the PCN program before he turns 65 years of age.
(c) Enrollment shall end effective the end of the month in which an individual turns 65 years of age.
(4) The eligibility agency only accepts applications during open enrollment periods. The eligibility agency limits the number it enrolls according to the funds available for the program and may stop enrollment at any time.
(a) The open enrollment period may be limited to:
(i) individuals with children under the age of 19 in the home;
(ii) individuals without children under the age of 19 in the home.
(b) The eligibility agency may not accept applications or maintain waiting lists during a period that enrollment of new individuals is stopped.
(5) The provisions of Subsection R414-302-6(1) and (4) apply to applicants and enrollees of PCN who are residents of institutions.
(6) An applicant or enrollee is not required to provide Duty of Support information to enroll in PCN. An adult whose eligibility for Medicaid has been denied or terminated for failure to cooperate with Duty of Support requirements may not enroll in the PCN program.

R414-310-5. Verification and Information Exchange.
(1) The provisions of Section R414-308-4 regarding verification of eligibility factors apply to applicants and enrollees of PCN.
(2) The Department shall safeguard information about applicants and enrollees to comply with the provisions of Section R414-301-5.
(3) The Department shall enter into agreements with other government agencies as outlined in Section R414-301-3.

R414-310-6. Creditable Health Coverage.
(1) The Department adopts and incorporates by reference 42 CFR 433.138(b) and 435.610, October 1, 2015 ed., and Section 1915(b) of the Compilation of the Social Security Laws, in effect January 1, 2016.
(2) An applicant who is covered under a group health plan or other creditable health insurance coverage as defined in 29 CFR 2590.701-4, July 1, 2013 ed., is not eligible for enrollment in PCN. This includes coverage under student health insurance and the Veteran's Administration Health Care System.
(a) An individual who is enrolled in the Utah Health Insurance Pool or who can receive health coverage through Indian Health Services may enroll in PCN.
(b) An individual who could enroll in Medicare is not eligible for enrollment in PCN, even if the individual must wait for a Medicare open enrollment period to apply.
(c) An individual who is eligible to enroll in the VA Health Care System, but who has not yet enrolled, may be eligible for PCN as long as the individual applies for and takes all necessary steps to enroll. Eligibility for PCN ends once the individual's coverage in the VA Health Care System begins.
(d) Individuals who are full-time students and who can enroll in student health insurance coverage are not eligible to enroll in PCN.
(3) An individual is not eligible for PCN if the individual becomes eligible for Refugee Medical without a spenddown as defined in Section R414-303-10. An individual who is eligible for Refugee Medical with a spenddown may choose to enroll in either Refugee Medical or PCN.
(4) An individual who has access to but has not yet enrolled in employer-sponsored health insurance coverage through an employer or a spouse's employer is not eligible for PCN if the individual's cost for the least expensive health insurance plan offered by the employer directly, or for the employer's default plan offered through Avenue H, does not exceed 15% of the countable MAGI based income for the individual's household.
(a) The cost of coverage includes a deductible if the employer-sponsored plan has a deductible.
(b) The eligibility agency will include in the cost of coverage for the spouse, the cost to enroll the employee, if the employee must be enrolled to enroll the spouse.
(c) The eligibility agency considers the individual to have access to coverage if the individual has had at least one opportunity to

enroll

(5) An individual who voluntarily terminates health insurance coverage is ineligible to enroll in PCN for 180 days from the date the coverage ended. The eligibility agency may not apply a 180-day ineligibility period in the following situations:

(a) Voluntary termination of COBRA.

(b) Voluntary termination of coverage through the Federally Facilitated Marketplace due to the loss of Advanced Premium Tax Credits (APTC).

(6) To be eligible to enroll in PCN, the 180-day ineligibility period must end by the earlier of the following dates or the eligibility agency shall deny the application:

(a) the last day of the open enrollment period during which the individual applies for PCN; or

(b) the last day of the month that follows the month in which the individual applies for PCN, if the open enrollment period does not expire before that following month ends.

(c) Enrollment in PCN may not begin before the 180-day ineligibility period ends.

R414-310-7. Household Composition and Income Provisions.

(1) The eligibility agency determines household composition and countable household income according to the provisions in R414-304-5.

(2) For an individual to be eligible to enroll in PCN, countable MAGI-based income for the individual must be equal to or less than 95% of the federal poverty guideline for the applicable household size.

R414-310-8. Budgeting.

(1) The Department shall apply the MAGI-based budgeting methodology defined at 42 CFR 435.603(c), (d), (e), (g) and (h), October 1, 2013 ed., which it adopts and incorporates by reference.

(2) The eligibility agency determines an individual's eligibility prospectively at application and at each review for continuing eligibility.

(a) The eligibility agency determines prospective eligibility by using the best estimate of the household's average monthly income that the agency expects the household to receive or to become available to the household during the upcoming review period.

(b) The eligibility agency shall include in the best estimate, reasonably predictable income expected to be received during the review period, such as seasonal income, contract income, income received at irregular intervals, or income received less often than monthly. The income will be prorated over the review period to determine an average monthly income.

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

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

(5) The eligibility agency may request additional information and verification about how a household is meeting expenses if the average household income appears to be insufficient to meet the household's living expenses.

R414-310-9. Assets.

An asset test is not required for PCN eligibility.

R414-310-10. Application and Signature.

(1) The provisions of Section R414-308-3 apply to PCN applicants, except for paragraph (9), (10) and the three months of retroactive coverage.

(2) A Medicaid or CHIP recipient may make a request during the open enrollment period for the agency to determine the individual's eligibility for PCN without completing a new application.

(3) The eligibility agency shall reinstate a medical case without requiring a new application if the agency closes the case in error.

(4) An applicant may withdraw an application for PCN any time before the eligibility agency completes an eligibility decision on the application.

R414-310-11. Eligibility Decisions and Reviews.

(1) The Department adopts and incorporates by reference 42 CFR 435.911 and 435.912, October 1, 2013 ed., regarding eligibility determinations.

(2) At application and review, the eligibility agency shall determine whether the individual is eligible for Medicaid, Refugee Medical or CHIP.

(a) An individual who qualifies for Medicaid or Refugee Medical without paying a spenddown or for Medicaid Work Incentive (MWI) without paying an MWI premium may not enroll in PCN.

(b) An applicant who is eligible for Medicaid, Refugee Medical or CHIP during the application month, or a Medicaid, Refugee Medical or CHIP recipient who requests PCN enrollment during an open enrollment period, may enroll in PCN in accordance with Subsection R414-310-12(1).

(3) An individual open on Medicaid, Refugee Medical or UPP may request to enroll in PCN.

(a) A new application form is not required.

(b) The rules in Section R414-310-12 govern the effective date of enrollment.

(c) If the individual is moving from UPP, the eligibility agency shall waive the open enrollment requirement if there is no break in coverage.

(d) If the individual is moving from Medicaid or Refugee Medical, the eligibility agency shall waive the open enrollment period if the individual was previously on PCN, became eligible for Medicaid or Refugee Medical, and requests to reenroll in PCN without a break in coverage.

(e) If the individual is moving from Medicaid or Refugee Medical and was not previously on PCN, or there has been a break in coverage of one or more months, the individual must reapply during an open enrollment period.

(f) All other eligibility requirements must be met.

(4) The eligibility agency shall complete an eligibility determination for each application unless:

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

(b) the applicant dies;

(c) the applicant cannot be located; or

(d) the applicant does not respond to requests for information within the 30-day application period or by the verification due date, if the verification date is later.

(5) The eligibility agency shall complete a periodic review of an enrollee's eligibility for medical assistance in accordance with the requirements of 42 CFR 435.916.

(a) The agency may request a recipient to contact the agency to complete the eligibility review.

(b) The agency shall provide the recipient a written request for verification needed to complete the review.

(c) The agency shall provide proper notice of an adverse decision.

(d) If the agency cannot provide proper notice of an adverse decision, the agency extends eligibility to the following month to allow for proper notice.

(6) If a recipient fails to respond to a request to complete the review or fails to provide all requested verification to complete the review, the eligibility agency shall end eligibility effective the end of the month for which the agency sends proper notice to the recipient.

(a) If the recipient contacts the agency to complete the review or returns all requested verification within three calendar months of the closure date, the eligibility agency shall treat such contact or receipt of verification as a new application. The agency may not require a new application form.

(b) The application processing period applies to this request to reapply.

(c) Eligibility can begin in the month the client contacts the agency to complete the review if all verification is received within the application processing period.

(d) If the recipient fails to return the verification timely, but before the end of the three calendar months, eligibility becomes effective the first day of the month in which all verification is provided and the individual is found eligible.

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

(f) The eligibility agency shall waive the open enrollment requirement during these three calendar months.

(g) If the enrollee does not respond to the request to complete the review for PCN during the three calendar months immediately following the review closure date, the enrollee must reapply for PCN and meet all eligibility criteria.

(7) If the individual files a new application or makes a request to reenroll within the calendar month that follows the effective closure date when the closure is for a reason other than incomplete review, the eligibility agency shall waive the open enrollment period and process the request as a new application.

(8) The enrollee must reapply if the case closes for one or more calendar months for any reason other than an incomplete review.

(9) The eligibility agency shall comply with the requirements of 42 CFR 435.1200(e), regarding transfer of the electronic file for the purpose of determining eligibility for other insurance affordability programs.

R414-310-12. Effective Date of Enrollment and Enrollment Period.

(1) Subject to the limitations in Sections R414-306-4 and R414-310-6, the effective date of PCN enrollment is the first day of the application month with the following exceptions:

(a) An applicant may be eligible for PCN if the applicant applies during an open enrollment period and will turn 19 before the end of the month in which open enrollment ends.

(i) Enrollment in PCN may not begin before an individual turns 19 years of age.

(ii) If an applicant qualifies for Medicaid or CHIP in the application month, enrollment in PCN begins the month after eligibility for Medicaid or CHIP ends.

(b) If the individual is moving from UPP, the effective date of enrollment is the first day after the health insurance coverage ends.

(c) If the individual is moving from Medicaid, or is eligible for Medicaid in the application month or the month following the application month, the effective date of enrollment is the first day of the month after Medicaid coverage ends. To enroll in PCN, Medicaid

~~eligibility must end by the end of the month following the application month.~~

~~(2) The effective date of reenrollment for PCN after the eligibility agency completes the periodic review is the first day after either the review month or due process month. Subsection R414-310-11(5) defines the effective date of reenrollment when the enrollee completes the review process in the three calendar months after the case is closed for incomplete review.~~

~~(3) The eligibility agency shall end eligibility for any of the following reasons:~~

~~(a) the individual turns 65 years of age;~~

~~(b) the individual enrolls in a health coverage plan as defined in Subsection 414-310-6(2);~~

~~(c) the individual gains access to an employer-sponsored health plan that meets the requirements of Subsection R414-310-6(2);~~

~~(d) a change in income or household composition results in the individual exceeding the income limit;~~

~~(e) the individual dies;~~

~~(f) the individual moves out of state or cannot be located; or~~

~~(g) the individual enters a public institution or an Institution for Mental Disease.~~

~~(4) An enrollee who gains access to or enrolls in an employer-sponsored health plan may switch to the UPP program if the enrollee meets UPP eligibility requirements.~~

~~R414-310-13. Change Reporting and Benefit Changes.~~

~~(1) Unless otherwise stated, the provisions in Section R414-308-7 apply to the PCN program.~~

~~(2) Reportable changes are defined in Subsection R414-310-3(2).~~

~~(3) For a decrease in income, the following provisions apply:~~

~~(a) If a change is already anticipated in a best estimate of income, the eligibility agency may only re-determine eligibility if the enrollee requests a redetermination of benefits.~~

~~(b) If a change is not anticipated, the agency shall re-determine eligibility.~~

~~(c) If a change makes the enrollee eligible for Medicaid, the effective date of the change is the first day of the month of report, if the change is verified timely.~~

~~(d) If a change is not verified timely, the change is effective on the first day of the month the change is verified.~~

~~(4) If an enrollee requests enrollment for a spouse, the application date for the spouse is the date of the request, and the following provisions apply:~~

~~(a) The eligibility agency does not require a new application;~~

~~(b) Eligibility is determined in accordance with Section R414-310-11;~~

~~(c) The effective date of enrollment is determined in accordance with Section R414-310-12; and~~

~~(d) The applicant must meet all other eligibility requirements.~~

~~R414-310-14. Notice and Termination.~~

~~(1) The Department adopts and incorporates by reference 42 CFR 431.206, 431.210, 431.211, 431.213, 431.214, and 435.919, October 1, 2013 ed.~~

~~(2) The eligibility agency shall notify an applicant or enrollee in writing of the eligibility decision made on the application or the review.~~

~~(3) The eligibility agency shall end an individual's enrollment upon enrollee request or upon discovery that the individual is no longer eligible.~~

~~R414-310-15. Improper Medical Coverage.~~

~~(1) Improper medical coverage occurs when:~~

~~(a) an individual receives medical assistance for which the individual is not eligible, including benefits that the individual receives pending a fair hearing or during an undue hardship waiver if the enrollee fails to act as required by the eligibility agency;~~

~~(b) an individual receives a benefit or service that is not part of the benefit package for which the individual is eligible;~~

~~(c) an individual pays too much or too little for medical assistance benefits; or~~

~~(d) the Department pays too much or too little for medical assistance benefits on behalf of an eligible individual.~~

~~(2) An individual who receives benefits under PCN for which the individual is not eligible must repay the Department for the cost of the benefits that the individual receives.~~

~~(3) An alien and the alien's sponsor are jointly liable for benefits that an individual receives for which the individual is not eligible.~~

~~(4) An overpayment of benefits includes all amounts paid by the Department for medical services or other benefits on behalf of an enrollee, or for the benefit of the enrollee during a period in which the enrollee is not eligible to receive the benefits.~~

~~KEY: Medicaid, primary care, demonstration~~
~~Date of Enactment or Last Substantive Amendment: March 28, 2017~~
~~Notice of Continuation: March 11, 2022~~
~~Authorizing, and Implemented or Interpreted Law: 26-18-1; 26-1-5; 26-18-3~~]

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF PROPOSED RULE		
TYPE OF FILING: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-504**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 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
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:

R414-504. Nursing Facility Payments.

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

The purpose of this change is to include provisions, under a moratorium exception, for major renovation in nursing care facilities.

4. Summary of the new rule or change:

This amendment includes an additional definition for major renovation and specifies payment methodology and procedures under a moratorium exception. It also restructures and renumbers the definitions in Section R414-504-2 to be in alphabetical order.

Fiscal Information

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

A) State budget:

There is no impact to the state budget as these changes are covered under previous allocations by the Legislature.

B) Local governments:

There is no impact on local governments as they neither fund nor administer nursing facilities under the Medicaid program.

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

There is no impact on small businesses as these changes are covered under previous allocations by the Legislature.

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

There is no impact on non-small businesses as these changes are covered under previous allocations by the Legislature.

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

There is no impact to other persons or entities as these changes are covered under previous allocations by the Legislature.

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

There are no compliance costs to a single person or entity as these changes are covered under previous allocations by the Legislature.

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. Businesses will see neither costs nor revenue as these changes are covered under previous allocations by the Legislature.

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	Title 26B, Chapter 3	

Incorporations by Reference Information

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

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

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

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

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

Public Notice Information

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

A) Comments will be accepted until:	01/31/2024

B) A public hearing (optional) will be held:

Date (mm/dd/yyyy)**:**	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**

To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.

9. This rule change MAY become effective on:	02/07/2024

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

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	12/14/2024

R414. Health and Human Services, [~~Health Care Financing, Coverage and Reimbursement Policy~~]Integrated Healthcare.
R414-504. Nursing Facility Payments.
R414-504-2. Definitions.

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

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

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

([~~1~~]3) "Behaviorally complex resident" means a long-term care resident with a severe, medically based behavior disorder, including traumatic brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgment, retention of information or decision-making skills, or a resident, who meets the Medicaid criteria for nursing facility level of care and who has a medically based mental health disorder or diagnosis and has a high level resource use in the nursing facility not currently recognized in the case mix.

([~~2~~]4) "Case mix index" means a score assigned to each facility based on the average of the Medicaid patients' case mix scores for that facility.

([~~3~~]5) "Case mix score" means the acuity or frailty of a resident based on medical needs resulting in a weight used to calculate rates.

(6) "Exception qualifying major renovation" means for purposes of a moratorium exception, a project in a facility that undergoes major renovations that involve significant structural changes of the physical facility and requires review and approval under Rule 432-4. The renovation includes a cost greater than or equal to $5,000 for total licensed beds and excludes flooring and paint.

([4]7) "Facility case mix rate" means the rate the Department issues to a facility for a specified period. This rate utilizes the case mix index for a provider, labor wage index application, and other case mix-related costs.

(8) "Fair rental value (FRV) data report" means a report that provides the Department with information related to capital improvements to be included in the FRV calculation.

([~~5~~]9) "FCP" means the facility cost profile report filed by the provider on an annual basis.

(10) "Major renovation" means, as used in the fair rental value calculation, a capitalized project with a cost equal to or greater than $500 for a licensed bed. A renovation extends the life, increases the productivity, or significantly improves the safety, such as by asbestos removal, of a facility as opposed to repairs and maintenance that either restore the facility to, or maintain it at its normal or expected service life. Vehicle costs are not a major renovation capital expenditure.

([~~6~~]11) "Minimum data set" (MDS) means a set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for residents of long-term care facilities certified to participate in Medicaid.

([~~7~~]12) "Nursing costs" means the current costs from the annual FCP report reported on lines 070-012 Nursing Admin Salaries and Wages, 070-013 Nursing Admin Tax and Benefits, 070-040 Nursing Direct Care Salaries and Wages, 070-041 Nursing Direct Care Tax and Benefits, and 070-050 Purchased Nursing Services.

([~~8~~]13) "Nursing facility" or "facility" means a Medicaid-participating nursing facility, skilled nursing facility, or a combination thereof, as defined in 42 USC 1396r (a), 42 CFR 440.150, 42 CFR 442.12, and Section 26B-2-201.

([~~9~~]14) "Patient day" means the care of one patient during a day of service, excluding the day of discharge.

(1[~~0~~]5) "Patient-driven payment model" (PDPM) means the Medicare prospective payment system for classifying skilled nursing facility patients in a covered Medicare Part A stay.

(1[~~1~~]6) "Property costs" means the fair rental value (FRV) established by this rule.

[~~(12) "Fair rental value (FRV) data report" means a report that provides the Department with information related to capital improvements to be included in the FRV calculation.~~

~~(13) "Bed addition" means, as used in the fair rental value calculation, a capitalized project that adds additional beds to the facility. This must be new and complete construction. An increase in total licensed beds and new construction costs support a claim~~

~~of additional beds.~~

~~(14) "Bed replacement" means, as used in the fair rental value calculation, a capitalized project that furnishes a bed in the place of another, previously existing bed. Room remodeling is not a replacement of beds. This must be new and complete construction.~~

~~(15) "Major renovation" means, as used in the fair rental value calculation, a capitalized project with a cost equal to or greater than $500 for a licensed bed. A renovation extends the life, increases the productivity, or significantly improves the safety, such as by asbestos removal, of a facility as opposed to repairs and maintenance that either restore the facility to, or maintain it at its normal or expected service life. Vehicle costs are not a major renovation capital expenditure.~~]

R414-504-6. Moratorium Exception for Major Renovation as Allowable.

(1) In accordance with Subsection 26B-3-311(7), a facility that requests to include beds as part of an exception qualifying major renovation, must submit to the Division of Integrated Healthcare an application within six months of approval of completing the renovation.

(2) The requirement of $5,000 for each bed excludes interest payments, and calculates costs related only to the exception qualifying major renovation as prescribed under Subsection 26B-3-311(7).

KEY: Medicaid
Date of Last Change: July 1, 2023
Notice of Continuation: October 12, 2022
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF CHANGE IN PROPOSED RULE		
Title No. - Rule No. - Section No.		
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	
Room number:		
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 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 amendment 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 change clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule, published in the 11/15/2023 State Bulletin, 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 change clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule, published in the 11/15/2023 State Bulletin, 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 change clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule, published in the 11/15/2023 State Bulletin, 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 change clarifies provisions within the text and makes other grammatical and restructuring changes. The original filing of this rule, published in the 11/15/2023 State Bulletin, 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, published in the 11/15/2023 State Bulletin, 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

Incorporations by Reference Information

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

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

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

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

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

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		
B) A public hearing (optional) will be held:		
Date (mm/dd/yyyy)**:**	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**

To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.

9. This rule change MAY become effective on:	
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	03/12/2024

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

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

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

(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 make 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.

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; and

(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.

(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

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

[~~(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 positive, the managed care entity shall pay the hospital within 30 calendar days of notification from the department.

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

(c) If the hospital fails to pay the managed care entity within 30 days, the department may suspend future directed payments to the hospital until the hospital pays the full amount..

(d) The managed care entity shall pay the department the penalty amount it receives from the hospital within 30 calendar days of receipt. If the managed care entity fails to pay the department within 30 days, the department may suspend payments to the managed care entity until the department receives 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: 2023
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF EMERGENCY (120-DAY) RULE		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-60-7**	**Filing ID: Office Use Only**
Effective Date:	**04/01/2024**	

Agency Information

1. Department:	Health and Human Services	
Agency:	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 or section catchline:

R414-60-7. Reimbursement

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

This emergency rule addresses a significant disruption to the pharmacy point of sale system affecting Medicaid users in the state. The purpose of this change is to allow the Medicaid division director flexibility to waive the 24-day limit on pharmacy dispensing fees if there is a significant disruption to the pharmacy point of sale system.

4. Summary of the new rule or change:

This emergency filing allows the Medicaid division director flexibility to waive the 24-day limit on pharmacy dispensing fees due to the system interruption to the pharmacy point of sale system that resulted in extensive downtime and increased administrative workload for pharmacy providers. It also updates the agency name within the rule title.

5A) The agency finds that regular rulemaking would:

☒ cause an imminent peril to the public health, safety, or welfare;

☐ cause an imminent budget reduction because of budget restraints or federal requirements; or

☐ place the agency in violation of federal or state law.

B) Specific reasons and justifications for this finding:

The department needs the ability to waive the 24-day limit to pharmacy dispensing fees in the event the Medicaid point of sale system experiences a system interruption that results in extensive downtime and increased administrative workload for pharmacy providers.

An exception to the 24-day limit to pharmacy dispensing fees provides a pathway for pharmacies to fill medications for Medicaid members and be compensated for the additional workload during the system interruption that results in extended downtime until the Medicaid pharmacy claims can be submitted and processed for payment using usual pathways.

Additionally, the agency must facilitate the pharmacy's ability to remain a viable business entity and remain in the network for member access to medically necessary services.

Fiscal Information

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

A) State budget:
Due to the time constraints of the current emergency, the department is unable to accurately estimate potential fiscal impacts, as an estimation would require the agency to slow the process of filing this emergency and therefore cause an imminent peril to the public health, safety, or welfare. As such, there is insufficient information to estimate the fiscal impact of this change to the state budget.
B) Local governments:
Due to the time constraints of the current emergency, the department is unable to accurately estimate potential fiscal impacts, as an estimation would require the agency to slow the process of filing this emergency and therefore cause an imminent peril to the public health, safety, or welfare. As such, there is insufficient information to estimate the fiscal impact of this change to local governments.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
Due to the time constraints of the current emergency, the department is unable to accurately estimate potential fiscal impacts, as an estimation would require the agency to slow the process of filing this emergency and therefore cause an imminent peril to the public health, safety, or welfare. As such, there is insufficient information to estimate the fiscal impact of this change to small businesses.
D) Persons other than small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**
Due to the time constraints of the current emergency, the department is unable to accurately estimate potential fiscal impacts, as an estimation would require the agency to slow the process of filing this emergency and therefore cause an imminent peril to the public health, safety, or welfare. As such, there is insufficient information to estimate the fiscal impact of this change to other persons or entities.
E) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**
Due to the time constraints of the current emergency, the department is unable to accurately estimate potential fiscal impacts, as an estimation would require the agency to slow the process of filing this emergency and therefore cause an imminent peril to the public health, safety, or welfare. As such, there is insufficient information to estimate the fiscal impact of this change to a single person or entity.
F) Comments by the department head on the fiscal impact this rule may have on businesses (Include the name and title of the department head):
The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this fiscal analysis. Due to the time constraints of the current emergency, the department is unable to accurately estimate potential fiscal impacts, as an estimation would require the agency to slow the process of filing this emergency and therefore cause an imminent peril to the public health, safety, or welfare. As such, there is insufficient information to estimate the fiscal impact of this change to businesses. -Tracy S. Gruber, Executive Director

Citation Information

7. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:		
Section 26B-1-213	Section 26B-3-108	

Incorporations by Reference Information

8. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**	
A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials

incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 304, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying the effective date and publication in the *Utah State Bulletin.*			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	

R414. Health and Human Services, [~~Health Care Financing, Coverage and Reimbursement Policy~~]Integrated Healthcare.
R414-60. Medicaid Policy for Pharmacy Program.
R414-60-7. Reimbursement.

(1) A pharmacy may not submit a charge to Medicaid that exceeds the pharmacy's usual and customary charge.

(2) Covered outpatient drugs are reimbursed as outlined in Attachment 4.19-B of the [~~Utah~~]Medicaid State Plan.

(3) A pharmacy that participates in the 340B program and uses medications obtained through the 340B program to bill Medicaid, must submit the acquisition cost of the medication on the claim.

(4) A pharmacy that participates in the federal supply schedule and uses medications obtained through the schedule to bill Medicaid, must submit the acquisition cost of the medication on the claim unless the claim is reimbursed as a bundled charge or all-inclusive rate.

(5) A pharmacy that obtains and uses medications at a nominal price must submit the acquisition cost of the medication on the claim.

(6) Dispensing fees are outlined in Attachment 4.19-B of the [~~Utah~~]Medicaid State Plan. Medicaid pays the lesser of the assigned dispensing fee or the submitted dispensing fee.

(7) Medicaid pays a pharmacy only one dispensing fee every 24 days for each covered outpatient drug.

(a) In the event the Medicaid point of sale system experiences a system interruption that results in extensive downtime and increased administrative workload for pharmacy providers, the Medicaid division director may waive the 24-day limit on dispensing fees.

(8) Medicaid pays a provider that immunizes a Medicaid member who is 19 years of age or older, for the cost of the immunization plus a dispensing fee. Medicaid pays the lesser of the allowed or submitted charges.

(9) A provider that immunizes a Medicaid member who is 18 years of age or younger, may only be eligible for a dispensing fee with no reimbursement for the immunization. Immunizations for Medicaid members who are 18 years of age or younger must be obtained through the Vaccines for Children program.

(10) Diabetic supplies listed on the Utah Medicaid PDL are reimbursed at the lesser of the wholesale acquisition cost with no dispensing fee or the billed charges.

(11) Pursuant to Section 58-17b-805, a dispensing medical practitioner may prescribe and dispense medication directly to a patient if providing outpatient cancer therapy. Details of reimbursement are found on the Medicaid website at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

KEY: Medicaid
Date of Last Change: October 11, 2023
Notice of Continuation: March 11, 2022
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108