DIH SPA Summary 1-8-26	Public Notice Date	Proposed Effective Date	Target Date or Date Submitted to CMS	CMS Approval Date	CMS Approved Effective Date	MCAC Present Date
UT-25-0024 Elimination of Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage; In accordance with the Consolidated Appropriations Act, this amendment removes the provision of optional continuous eligibility for pregnant individuals, who were previously eligible through the last day of the month in which a 12-month postpartum period ends.	**N/A**	**1-1-16**	**12-11-25**			**1-8-26**
UT-25-0026 Medication-Assisted Treatment for Opioid Use Disorders; In accordance with the Consolidated Appropriations Act of 2024, this amendment makes permanent treatment services and medication-assisted treatment drugs for opium use disorders that include methadone, naltrexone, and buprenorphine.	**N/A**	**10-1-25**	**12-19-25**			**1-8-26**
UT-25-0027 Physical Therapy and Occupational Therapy; This amendment aligns the Medicaid State Plan with recently enacted changes to the physical therapy (PT) and occupational therapy (OT) practice acts and current PT and OT policy.	**12-28-25**	**1-1-26**	**12-31-25**			**1-8-26**
UT-26-0001 Behaviorally Complex Add-On Rate; In accordance with HB 347 and appropriations passed during the 2025 Session of the Utah Legislature, this amendment updates provisions that require the state to pay an add-on rate to nursing facilities which document residents who have behaviorally challenging problems.	**12-14-25**	**1-1-26**	**1-7-26**			**1-8-26**
UT-26-0002 Nursing Facility Fair Rental Value; This amendment includes a provision to annually update the base value of licensed beds in nursing facilities by applying an inflation adjustment factor to the prior year's value. This amendment also specifies the maximum allowable age of a nursing facility.	**1-25-26**	**1-1-26**	**1-30-26**			**1-8-26**
UT-26-0003 Maximum Allowable Cost and 340B Pricing; This amendment clarifies current pharmacy policy regarding maximum allowable cost and 340B Pricing to remove misunderstanding or subjective interpretation.	**12-28-25**	**1-1-26**	**1-30-26**			**1-8-26**

UT - Submission Package - UT2025MS0003O - (UT-25-0024) - Eligibility

VIEW PRINT PREVIEW

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage

MEDICAID | Medicaid State Plan | Eligibility | UT2025MS0003O | UT-25-0024

Spell Check Instructions | Request System Help

CMS-10434 OMB 0938-1188

Not Started In Progress Complete

Package Header

Package ID	UT2025MS0003O	**SPA ID**	UT-25-0024
Submission Type	Official	**Initial Submission Date**	11/17/2025
Approval Date	N/A	**Effective Date**	1/1/2026
Superseded SPA ID	UT-23-0017		
	System-Derived		

View Implementation Guide

VIEW ALL RESPONSES

The state provides continuous eligibility for pregnant individuals and extended postpartum coverage in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Pregnant Women

Collapse

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan, without regard to any changes in income that otherwise would result in ineligibility, through the last day of the month in which a 60-day postpartum period (beginning on the last day of the pregnancy) ends. This extension does not apply to pregnant individuals eligible only during a period of presumptive eligibility.

B. Optional 12-Month Postpartum Continuous Eligibility for Pregnant Women

Collapse

The state provides continuous eligibility to pregnant individuals who were eligible and enrolled under the state plan while pregnant (including during a period of retroactive eligibility) through the last day of the month in which a 12-month postpartum period (beginning on the last day of the pregnancy) ends.

- ○ Yes
- ◉ No

C. Additional Information (optional)

Expand

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1-~~B~~ A Amount, Duration, and Scope of Services

[Please check the box below to indicate if this benefit is provided for the categorically needy (3.1-A) or medically needy only (3.1-B)]

1905(a)(29) MAT as described and limited in Pages 1 to 6 of Attachment #29 within ATTACHMENT 3.1-~~B~~A.

General Assurances
[Select all three checkboxes below.]

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020.

The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

Service Package
The state covers the following counseling services and behavioral health therapies as part of MAT: [Please describe in the text fields as indicated below.]

Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Psychotherapy

Psychotherapy means psychotherapy with patient, family psychotherapy with patient present, family psychotherapy without patient present*, group psychotherapy, and multiple family group psychotherapy*.

Pharmacologic Management (Evaluation and Management Services)*

Pharmacologic management means the evaluation and management of the member's health issues, prescription, review and monitoring of medication(s) and the medication regimen, providing information, and administering medications as appropriate. The review of the member's medications and medication regimen includes dosage, effect the medication(s) is having on the member's symptoms, and side effects. The provision of appropriate information should address direction for proper and safe usage of medications.

Nurse Medication Management

Nurse medication management means the review and monitoring of the member's health issues, medication(s) and medication regimen, providing information, and administering medications as appropriate. The review of the member's medications and medication regimen includes dosage, effect the medication(s) is having on the member's symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage of medications.

Therapeutic Behavioral Services*

Therapeutic behavioral services mean~~s~~ behavioral interventions to assist members with specific identified behavior problems. The service may be provided to an individual or group.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Peer Support Services*

Peer support services means services provided for the primary purpose of assisting in the rehabilitation and recovery of members with substance use disorders.

Peer support services may be provided to an individual or a group. On occasion, it may not be possible to meet with the peer support specialist in which case a telephone contact with the member would be allowed.

Peer support services are designed to promote recovery. Peers offer a unique perspective that members find credible; therefore, peer support specialists are in a position to build alliances and instill hope. Peer support specialists lend their unique insight into substance use disorders and what makes recovery possible.

Peer support services must be recommended by an individual authorized under state law to perform psychiatric diagnostic evaluations and develop treatment plans.

*These services can involve the participation of a non-Medicaid eligible individual but are provided for the direct benefit of the member. The service must actively involve the member in the sense of being tailored to the member's individual needs. There may be times when, based on clinical judgment, the member is not present during the delivery of the service, but remains the focus of the service.

Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

The following practitioners are qualified to provide/furnish P~~p~~sychotherapy within their scope of practice, including meeting all competency and educational requirements pursuant to state law.

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Section 1905(a)(29) Medication Assisted Treatment (MAT)

(Psychotherapy continued)
Services and required supervision are provided in accordance with state scope of practice laws governing the applicable profession.

Licensed Practitioners: mental health therapists including physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; advanced practice registered nurses (APRNs) and APRN interns specializing in psychiatric mental health nursing; psychologists qualified to engage in the practice of mental health therapy; physician assistants specializing in mental health care; clinical social workers; marriage and family therapists; ~~and~~ associate marriage and family therapists; clinical mental health counselors; ~~and~~ associate clinical mental health counselors; master addiction counselors; and associate master addiction counselors.

Certified Practitioners: licensed certified psychology residents qualifying to engage in the practice of mental health therapy; licensed certified social workers; and licensed certified social worker interns.

Individuals exempted from licensure as a mental health therapist in accordance with state law: students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee; and individuals employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, who subsequently have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision.

other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

~~(Psychotherapy continued)~~

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Other: Licensed substance use disorder counselors and individuals enrolled in a qualified substance use disorder counseling education program exempted from licensure in accordance with state law may co-facilitate group psychotherapy with a licensed mental health therapist or

Section 1905(a)(29) Medication Assisted Treatment (MAT)

(Psychotherapy continued)

licensed certified mental health therapist specified above. Licensed behavioral health coaches may co-facilitate group psychotherapy with a licensed mental health therapist.

The following practitioners are qualified to provide/furnish Pharmacological Management (Evaluation and Management Services) ~~services~~ within their scope of practice, including meeting all competency and educational requirements pursuant to state law. Services and required supervision are provided in accordance with state scope of practice laws governing the applicable profession.

Licensed Practitioners: physicians and surgeons or osteopathic physicians regardless of specialty; APRNs and APRN interns regardless of specialty; and other medical practitioners licensed under state law, most commonly physician assistants regardless of specialty.

The following practitioners are qualified to provide/furnish Nurse Medication Management services within their scope of practice, including meeting all competency and educational requirements pursuant to state law. Services and required supervision are provided in accordance with State scope of practice laws governing the applicable profession.

Licensed Practitioners: registered nurses; and practical nurses.

Individuals exempted from licensure in accordance with state law: registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the state's licensing division under the supervision of qualified faculty, staff, or designee.

The administration of medications may also be performed by licensed medical assistants under the supervision of a licensed physician, surgeon or osteopathic physician, licensed APRN, licensed physician assistant, or licensed registered nurse.

Section 1905(a)(29) Medication Assisted Treatment (MAT)

The following practitioners are qualified to provide/furnish Therapeutic Behavioral Services within their scope of practice, including meeting all competency and educational requirements pursuant to state law. Services and required supervision are provided in accordance with state scope of practice laws governing the applicable profession.

Licensed Practitioners: mental health therapists including physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; advanced practice registered nurses (APRNs) and APRN interns specializing in psychiatric mental health nursing; psychologists qualified to engage in the practice of mental health therapy; physician assistants specializing in mental health care; clinical social workers; marriage and family therapists; associate marriage and family therapists; clinical mental health counselors; associate clinical mental health counselors~~.~~; master addiction counselors; and associate master addiction counselors.

Certified Practitioners: licensed certified psychology residents qualifying to engage in the practice of mental health therapy; licensed certified social workers; and licensed certified social worker interns.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

Individuals exempted from licensure as a mental health therapist in accordance with state law: students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee; and individuals employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, who subsequently have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision.

Other licensed practitioners: social service workers; substance use disorder counselors; registered nurses; ~~and~~ practical nurses~~.~~; and behavioral health coaches.

Section 1905(a)(29) Medication Assisted Treatment (MAT)

(Therapeutic Behavioral Services continued)
Other individuals exempted from licensure in accordance with state law: individuals working toward licensure as a social service worker under supervision of a licensed mental health therapist; registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the state's licensing division under the supervision of qualified faculty, staff, or designee; and individuals enrolled in a qualified substance use disorder education program under the supervision of a mental health therapist or licensed advanced substance use disorder counselor.

The following practitioners are qualified to provide/furnish Peer Support Services due to meeting all age, competency or educational requirements pursuant to state law. Services and required supervision are provided in accordance with state requirements.
Certified Practitioners: Certified peer support specialists.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

To become certified, individuals must successfully complete a peer support specialist training curriculum developed by the State of Utah, Department of Health and Human Services, ~~Division~~ Office of Substance Use and Mental Health ~~(DSAMH)~~(OSUMH), in consultation with national experts in the field of peer support. Training is provided by ~~DSAMH~~ OSUMH or a qualified individual or organization sanctioned by ~~DSAMH~~ OSUMH. At the end of the training individuals must successfully pass a written examination. Successful individuals receive a written peer support specialist certification from ~~the DSAMH~~ OSUMH. Certified peer support specialists must also successfully complete any continuing education requirements ~~the DSAMH~~ OSUMH requires to maintain certification.

Certified peer support specialists provide services under the supervision of a licensed mental health therapist or licensed certified mental health therapist; an individual exempted from licensure as a mental health therapist in accordance with state law while employed as a

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State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

Section 1905(a)(29) Medication Assisted Treatment (MAT)

(Peer Support Services continued)

psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the use performance of their official duties for that agency or political subdivision; or licensed substance use disorder counselor when the service is provided to members with a substance use disorder.

Utilization Controls ☐ The state has drug utilization controls in place. (Check each of the following that apply) ☐ Generic first policy ☐ Preferred drug lists ☐ Clinical criteria ☐ Quantity limits

☐ The state does not have drug utilization controls in place.

Limitations
MAT drugs may be subject to generic first policies, clinical criteria, placement on a preferred drug list, and limitations on quantity. There are no limits on the amount, duration and scope of the counseling and behavioral therapies.

State Plan under Title XIX of the Social Security Act State/Territory: [Select State or Territory]

TN: 25-0026 Supersedes
TN: New

Approval Date:_____

Effective Date: 10-1-25

other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland

PHYSICAL THERAPY SERVICES

SERVICES

Physical therapy services by independent provider, group practice, rehabilitation facility, outpatient facilities, and hospital include:

The examination, evaluation, diagnosis, prognosis, and intervention under the direct supervision of a physical therapist of a client to prevent, correct, alleviate and limit physical disability, bodily malfunction, pain from injury, disease and other physical or mental disabilities.

LIMITATIONS

~~1. Physical therapy requires a physician order.~~

~~2. Physical therapy requires the attending physician to certify the client's need for therapy services.~~

~~3.~~1. Physical therapy requires a written plan of care~~.~~ ~~signed by the physician.~~

~~4.~~2. Physical therapy related to a stroke must be initiated within 60 days following the stroke and may continue only until the expected, reasonable level of function is restored.

~~5.~~3. Physical therapy is limited to 20 visits per calendar year.

~~6.~~4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

a. that the proposed services are medically appropriate; and

b. that the proposed services are more cost effective than alternative services.

OCCUPATIONAL THERAPY SERVICES

SERVICES

Outpatient occupational therapy services include:

Program planning, consultation, evaluation, and intervention under the direct supervision of an occupational therapist to provide the therapeutic use of everyday activities to promote health and wellness for clients at risk for developing illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.

LIMITATIONS

~~1. Occupational therapy requires a physician order.~~

~~2. Occupational therapy requires the attending physician to certify the client's need for therapy services.~~

~~3.~~1. Occupational therapy requires a written plan of care~~.~~ ~~signed by the physician.~~

~~4.~~2. Occupational therapy related to a stroke must be initiated within 90 days following the stroke and may continue only until the expected, reasonable level of function is restored.

~~5.~~3. Occupational therapy is limited to 20 visits per calendar year.

~~6.~~4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

a. that the proposed services are medically appropriate; and

b. that the proposed services are more cost effective than alternative services.

921 Case Mix Component

Minimum Data Set (MDS) data is used in calculating each facility's case mix index. This information is submitted by each facility and, as such, each facility is responsible for the accuracy of its data. (Inaccurate or incomplete data will be excluded from the calculation.) Case mix is determined by establishing a ~~C~~case ~~M~~mix weight for each Medicaid resident. Available ~~C~~case ~~M~~mix scores for each resident are combined with the scores of all other residents to establish a facility-wide case mix for all Medicaid residents in the facility. The facility-wide case mix is multiplied by a dollar conversion factor to arrive at a per diem amount for the facility payment rate. The "dollar conversion factor" is defined as the rate is established quarterly by the state. Raw food is considered to be included in this component.

The per resident day base rate, on average, for all facilities is composed of the three components; property component, ~~C~~case ~~M~~mix component and the flat rate component. An example of these components is as follows:

Component Amounts for July 1, 2022 (illustrative purposes only)

Property component:	$21.80
Case Mix Component:	$103.10
Flat Rate Component:	$92.67
Total Average Rate:	$217.57

Rates will be adjusted each July 1, based on the inflation factors adopted by the legislature, as set forth in Section 900, and FRV data that affect each of the components.

In addition to the base rate, the following add-on payments will be applied to qualifying facility payment rates in the proportion that the facility qualifies for the add-on factor. For example, effective March 1, 2026 ~~(as of 7/1/2022)~~:

SRS	$21.88
Behavioral Complex	
Tier 1	$63.40
Tier 2	$185.95~~$7.52~~

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Note: A resident may only be eligible for one add-on amount at any particular time. The facility case mix and resulting rate change will be computed quarterly.

ATTACHMENT 4.19-D

T.N. # 23-0006

Supersedes T.N. # 07-007

Approval Date November 28, 2023

Effective Date 7-1-23

900 RATE SETTING FOR NFs (Continued)

930 BEHAVIORALLY ~~CHALLENGING PATIENT~~ COMPLEX ADD-ON

Non ICF/IID nursing facilities that document residents who have behaviorally challenging problems will be paid an "add-on" rate. ~~The rate is $7.52 effective July 1, 2022. This add-on amount will be updated on an "as needed" basis or as noted in Section 900.~~

A resident who qualifies for the Behaviorally ~~Challenging Patient~~ Complex add-on rate shall not receive any other add- on amount (i.e., Specialized Rehabilitation Services, etc.). The resident must also meet the criteria for nursing facility level of care and have an approved nursing facility admission record prior to the add-on rate being approved. The add-on rate will be reimbursed at a tiered rate determined by the department after the application and documentation have been reviewed. Behaviors, their frequency of occurrence, and need for psychiatric inpatient stay will assist in establishing the appropriate tier level.

It is the responsibility of the provider to notify the department if the individual has a change in condition and may no longer qualify for this add-on rate. The department will conduct reviews of the behavioral intervention programs at least every six months and if the department finds that the individual no longer qualifies for the add-on rate and the nursing facility fails to notify the department timely, a recapture of funds will occur for any dates that were paid incorrectly.

To qualify for this add-on, a nursing facility must:

1) Demonstrate that the resident has a history of persistent disruptive behavior that is ongoing and 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 consistent wandering behavior with no rational purpose, is oblivious to their needs or safety, and places them self and others at significant risk of physical illness or injury (the presence of elopement or wandering behaviors alone, not in conjunction with aggressive or assaultive behaviors exhibiting a danger to self or others, does not qualify for the add-on rate);
   b) The resident engages in verbally abusive behavior where they threaten, scream or curse~~s~~ at others;
   c) The resident presents a threat of hitting, shoving, scratching, or sexually abusing other residents or staff; and/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) Inappropriate sexual behavior;
      iv) Disrobes in public;
      v) Smears or throws food or feces;
      vi) Hoards; or
      vii) R~~r~~ummages through others' belongings.
   e) The resident consistently refuses assistance with medication administration or

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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.

2) Demonstrate that an appropriate behavioral intervention program has been developed specifically for the resident and must demonstrate competency to adequately address the individual's behavior. All behavior intervention programs shall:.

~~a) All behavior intervention programs shall:~~

~~b)~~a) Be a precisely planned systematic application of the methods and experimental findings of behavioral science with the intent to reduce observable negative behaviors;

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

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

e)d) Incorporate a process for identifying and reinforcing a desirable replacement behavior; and

f) Include a program data sheet for each behavior, which must include a behavior baseline profile that consists of all the following:; and

g)e) Include a behavior baseline profile that consists of all of the following:

i) Applicant nameBehavior tracking sheets that include the date, time, location, and specific description of the undesirable behavior;

ii)i) Date, time, location, and specific description of the undesirable behavior;

iii)ii) Persons and conditions present before and at the time of the undesirable behavior;

iii) The frequency and severity of the behavior;

iv) Interventions for the undesirable behavior and their results; and

v) Recommendations for future action.

h) The interdisciplinary team shall include a behavior intervention plan written by a licensed professional familiar with behavior plans that includes consists of all of the following:

f)

i) The applicant's name, the date the plan is prepared, and when how the plan will be implementedused;

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, including ongoing behavior and intervention tracking sheets; and

v) The plan must be documented in the resident's comprehensive plan of care and reviewed quarterly by the nursing facility.

3) If the behaviors are a result of a serious mental illness or intellectual disability/related condition the resident must have a Preadmission Screening and Resident Review (PASRR) Level II Evaluation that outlines the behaviors and recommends this add-on rate program to qualify for tier 2. .

3)

4) Tiered rates have been established to cover the broad milieu of patient needs. The tier levels are based on behaviors and their frequency. In addition to the above requirements in 1) through 3), the The following additional requirements must be met is a guide to qualify for reimbursement under one of the tiersfor applying for the appropriate tier:

a) **Tier 1**: Behaviors requiring a minimal/moderate amount of intervention or assistance that de-escalate quickly and the residents are easily redirected by nursing facility staff.

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i) Must meet nursing facility level of care criteria and have an approved nursing facility admission record for the dates of service requested.
ii) Behavior(s) must be related to a chronic condition or diagnosis and cannot be related to an acute condition that clears quickly.
iii) Must include a consecutive 30-day long behavior identification period while admitted to the nursing facility. This period will allow for identification of behaviors and an opportunity to provide remediation of environmental and social factors that likely precipitate or reinforce the inappropriate behavior.
iv) Behavior(s) must require ongoing intervention. The behaviors or interventions must occur at least three days per week.
v) The nursing facility interdisciplinary team can write and implement the behavior intervention plan, per section 2.

b) **Tier 2**: Serious behaviors requiring frequent intervention by specially trained staff.
i) Must meet nursing facility level of care criteria and have an approved nursing facility admission record for the dates of service requested.
ii) Behavior(s) must be related to a chronic condition or diagnosis and cannot be related to an acute condition that clears quickly.
iii) Required training for staff in managing challenging behaviors, de-escalation techniques, and core mental/behavioral health topics as required through an annual contract.
iv) If the behaviors are related to a mental health condition or intellectual disability/related condition, the resident must have a PASRR Level II Evaluation outlining the behaviors and a recommendation for application to the Tier 2 program.
v) If the behaviors are a result of a medical condition, the behaviors must be clearly outlined by the treating psychiatrist/psychologist and include a recommendation for application to the Tier 2 program.
vi) The facility must be contracted with an independent entity providing behavioral supports services and psychiatry/psychological services. The entity will:
(A) Conduct comprehensive assessments;
(B) Assist in developing person-centered behavioral support plans;
(C) Deliver non-pharmacological interventions such as psychotherapy, peer support, and other therapeutic modalities; and
(D) Provide psychotropic medication management in coordination with the care team to ensure safe and effective use of medications.
vii) Must have access to a ~~C~~crisis ~~T~~team as needed.
viii) Initial assessments and behavioral support plans should be in place prior to admission if transferring from another facility to ensure a smooth transition and address behavior issues that may arise from the transfer.
ix) Behavior(s) must require ongoing intervention. The behaviors or interventions must occur four or more days per week.

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600 PROPERTY (Continued)

(I) The project must have been completed during a 24-month period and reported on the FRV Data Report for the reporting period used for the July 1 rate year and be related to the reasonable functioning of the nursing facility. Renovations unrelated to either the direct or indirect functioning of the nursing facility shall not be used to adjust the facility's age.

(II) The equivalent number of new beds is determined by dividing the cost of the project by the accumulated depreciation per bed of the facility's existing beds immediately before the project.

(III) The equivalent number of new beds is then subtracted from the total actual beds. The result is multiplied by the difference in the year of the completion of the project and the age of the facility, which age is based on the initial construction year or the last reconstruction or renovation project. The product is then divided by the actual number of beds to arrive at the number of years to reduce the age of the facility.

(b) A nursing facility's fair rental value per diem is calculated as follows:

~~As used in this subsection (b), "capital index" is the percent change in the Salt Lake City Location Factor as found in the two most recent annual R.S. Means Data.~~

(i) On July 1, 202604, the buildings and fixtures value per licensed bed is $85,660.06~~50,000~~. The base value per licensed bed shall be updated annually by applying an inflation adjustment factor of 1.84 percent to the prior year's value~~.~~. To this base value per licensed bed ~~$50,000~~ is added 10% ~~($5,000)~~ for land and 10% ~~($5,000)~~ for movable equipment. Each nursing facility's total licensed beds are multiplied by this amount to arrive at the "total bed value." The total bed value is trended forward by multiplying it by the capital index and adding it to the total bed value to arrive at the "newly calculated total bed value." The newly calculated total bed value is depreciated, except for the portion related to land, at 1.50 percent per year according to the weighted age of the facility. The maximum age of a nursing facility shall be 6635 years. There shall be no recapture of depreciation. ~~The base value per licensed bed is updated annually using the R.S. Means Data as noted above.~~ Beginning July 1, 2008, the 2007 base value per licensed bed is used for all facilities, except facilities having completed a qualifying addition, replacement or major renovation. These qualifying facilities have that year's base value per licensed bed used in its FRV calculation until an additional qualifying addition, replacement or major renovation project is completed and reported, at which time the base value is updated again.

S. PRESCRIBED DRUGS

Covered outpatient drugs will be reimbursed based on an established product cost plus a professional dispensing fee. The payment for individual prescriptions shall not exceed the amount billed. The amount billed must be no more than the usual and customary charge (U&C) to the private pay patient. The following methodology is used to establish Medicaid payments:

Effective for claims adjudicated on or after April 1, 2017, except as otherwise stated in this section and in addition to a reasonable professional dispensing fee as applicable, reimbursement for brand and generic covered outpatient drugs will be as follows:

The lesser of the Wholesale Acquisition Cost (WAC), Federal Upper Limit, National Average Drug Acquisition Cost (NADAC), Utah Maximum Allowable Cost (UMAC), or the Ingredient Cost Submitted.

Federal Upper Limit

The federal upper limit is the maximum allowable ingredient cost reimbursement established by the Federal government (e.g., Centers for Medicare and Medicaid Services (CMS) for selected multiple-source drugs. The aggregate cost of product payment for the drugs on the federal upper limit list will not exceed the aggregate established by the Federal government.

Ingredient Cost Submitted

Ingredient Cost Submitted is the actual acquisition cost. The actual acquisition cost must be net of any discounts the provider may receive to offset its acquisition cost (i.e., rebates to the provider, negotiated discounts, etc.).

Utah MAC

Utah MAC is the Maximum Allowable Cost reimbursement established by the State for selected drugs.

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S. PRESCRIBED DRUGS (Continued)

Covered Outpatient Drugs Purchased Through the 340B Program

Covered entities that purchase covered outpatient drugs through the 340B program and used the 340B covered outpatient drugs to bill Utah Medicaid are required to submit the 340B acquisition cost on the claim and identify the medications as being purchased through the 340B program.

The 340B actual acquisition cost is net of any discounts the provider may receive to offset its acquisition cost.

Payment for covered outpatient drugs purchased through the 340B program will be the lesser of the 340B acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

- Covered entities as described in Section 1927(a)(5)(B) of the Social Security are required to bill no more than their actual acquisition cost plus the professional dispensing fee.

Payment for covered outpatient drugs not purchased through the 340B program are to be submitted, and reimbursed, in accordance with the reimbursement rules under this section.

340B covered entities may not utilize contract pharmacies to bill Utah Medicaid unless the covered entity, contract pharmacy, and State Medicaid agency have a written agreement in place to prevent duplicate discounts.

Federal Supply Schedule

Providers that purchase covered outpatient drugs through the Federal Supply Schedule (FSS) and use the covered outpatient drugs to bill Utah Medicaid are required to submit the FSS acquisition cost on the claim, unless the reimbursement is made through a bundled charge or all-inclusive encounter rate.

Payment for covered outpatient drugs purchased through the FSS will be the lesser of the FSS acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

Payment for covered outpatient drugs not purchased through the FSS are to be submitted, and reimbursed, in accordance with the reimbursement rules of this section.

Nominal Price

Providers that purchase covered outpatient drugs at Nominal Price and use the covered outpatient drug to bill Utah Medicaid are required to submit the acquisition cost on the claim.

Payment for covered outpatient drugs purchased at Nominal Price will be the lesser of the Nominal Price acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

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