DMHF Rules Matrix 11-18-21

Rule Summary	Bulletin Publication	Effective
R414-510 Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education (Five-Year Review); The Department will continue this rule because it sets forth eligibility requirements for the Transition Program, includes provisions for program access, details educational aspects of the program, and establishes educational and referral requirements for individuals seeking ICF services.	**10-1-21**	**9-14-21**
R414-320-16 Benefits; The purpose of this change is to update the maximum adult reimbursement rate for each month, and to clarify provisions for children. This amendment, therefore, allots a new maximum reimbursement amount for adults up to $300 each month, and clarifies coverage and reimbursement for children. It also makes other clarifications and technical changes.	**11-1-21**	**12-8-21**
R414-10 Physician Services (Five-Year Review); The Department will continue this rule because it sets forth eligibility requirements, requirements for program access, and provisions for coverage. The Department recently amended this rule to update the scope of practice for physician assistants set forth in Title 58, Chapter 70a, and to make other clarifications.	**11-15-21**	**10-19-21**
R414-524 American Rescue Plan Act, Home and Community-Based Services Enhanced Funding (Emergency Rule); The purpose of this rule is to implement Section 9817 of the American Rescue Plan Act of 2021 (ARPA), to assist providers of home and community-based services (HCBS). This rule, therefore, enacts supplemental payments to HCBS providers, as allowed under ARPA, to provide economic relief to businesses affected by the Coronavirus (COVID-19) pandemic.	**11-15-21**	**10-29-21**
R414-516 Nursing Facility Non-State Government-Owned Upper Payment Limit Quality Improvement Program (Repeal and Reenact); The purpose of this rule is to define participation requirements for the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program. Some requirements of the repealed rule are reenacted in the proposed rule. In contrast to the repealed rule, the proposed rule focuses mainly on QI participation requirements, and does not include provisions for quality awards, construction, renovation, quality metrics, and staffing. The proposed rule also includes new definitions and new provisions for exceptions and holdings.	**11-15-21**	**12-22-21**
R414-523 Extraordinary Care Definition for Spousal Caregiver Compensation (New Rule); The purpose of this new rule, in accordance with S.B. 63 of the 2021 General Session, is to implement a definition for extraordinary care to use in the evaluation and authorization of caregiver compensation in applicable home and community-based services (HCBS) waiver programs. This amendment, therefore, implements a definition for extraordinary care to use in the evaluation and authorization of caregiver compensation in applicable HCBS programs. It also specifies limitations, spells out eligibility requirements, lists provisions for compensation, and specifies the Department's authority to deny a compensation request.	**11-15-21**	**12-22-21**

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

State of Utah
Administrative Rule Analysis
Revised June 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-510**	**Filing ID: (Office Use Only)**

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
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 person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:

Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education

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

Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules while Section 26-1-5 authorizes the Department to adopt rules as necessary for program implementation.

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

The Department received written comments from providers in the health care industry and from families of Medicaid patients who reside in intermediate care facilities (ICFs). These comments were the result of an amendment to the rule in 2019 that introduced provisions to educate members and families of the transition to home and community-based services (HCBS). These services provide greater flexibility and independence for Medicaid patients who do not need or wish to remain in an institutional facility. The amendment to the rule was based on a settlement agreement with the Disability Law Center (DLC) in 2018, which advocated for educating patients and families on the Transition Program. The comments the Department received expressed concern that services for patients in ICFs would diminish with increased focus on HCBS, that patients would not have the option to remain in ICFs, and that ICFs would lack necessary funding to provide quality care. Additionally, there were concerns that ICF patients who made the transition to HCBS would not have the same safety protocols.

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

The Department will continue this rule because it sets forth eligibility requirements for the Transition Program, includes provisions for program access, details educational aspects of the program, and establishes educational and referral requirements for individuals seeking ICF services. In response to the written comments, the Department maintains that it is committed to providing safe and quality services for patients in ICFs and HCBS settings, and that funding for both types of services shall remain.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.

Agency head or designee, and title:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	09/14/2021

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-510. Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education.
R414-510-1. Introduction and Authority.

(1) This rule implements the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF) Transition Program, and the education process required for individuals currently residing in ICFs and those considering ICF admission. ICF Transition Program participation is voluntary and allows an individual to transition from a privately-owned ICF to the Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions.

(2) This rule is authorized by Section 26-18-3. Waiver services are optional and provided in accordance with 42 CFR 440.225.

R414-510-2. Definitions.

(1) "Departments" means the Department of Health and the Department of Human Services.

(2) "Division of Services for People with Disabilities (DSPD)" means the entity within the Department of Human Services that has responsibility to plan and deliver an appropriate array of services and supports to persons with disabilities in accordance with Section 62a-5-102.

(3) "Guardian" means an individual who is legally authorized to make decisions on an individual's behalf.

(4) "Interested individual" means an individual who meets eligibility requirements and expresses interest, either directly or through a guardian, in participating in the Transition Program.

(5) "Intermediate Care Facilities" means privately owned intermediate care facilities for individuals with intellectual
disabilities.

(6) "Length of stay" means the length of time an individual has continuously resided in ICFs in the state. The Departments consider a continuous stay to include a stay in which an individual has a temporary break in stay of no more than 31 days. Breaks in stay due to inpatient hospitalization, admission to a nursing facility, or a temporary leave of absence, if due to health concerns related to Coronavirus (COVID-19), will not be considered a break in stay when evaluating Subsection R414-5103(1)(e).

(7) "Representative" means an individual, who is not a guardian, and does not have decision-making authority, but is
identified as an individual who assists a potential Transition Program participant.

(8) "State staff" means employees of the Division of Medicaid and Health Financing or DSPD.

(9) "Transition Program" means the Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program.

(10) "Waiver" means the Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions (CSW).

R414-510-3. Eligibility Requirements for the Transition Program.

(1) Waiver services are potentially available to an individual who:

(a) receives ICF benefits under the Medicaid State Plan;

(b) has been diagnosed with an intellectual disability or a related condition;

(c) meets ICF level-of-care criteria defined in Section R414-502-8;

(d) meets state funding eligibility criteria for DSPD found in Subsection 62A-5-102(4);

(e) and has at least a 12-month length of stay in any Medicaid-certified, privately owned ICF located in Utah.

(2) The Department of Health may consider a length-of-stay exemption to Subsection (1)(e) when an individual, or representative, requests an exception to the minimum length-of-stay requirement during the COVID-19 public health emergency declared by the federal government or the state.

(3) To make a request for a length-of-stay exemption, an individual or representative, must submit a

written request to the Department of Health and include the rationale for the request, including the anticipated risk if the individual remains in the intermediate care facility.

(4) Before deciding upon a request, the Department of Health:

(a) may consult with its healthcare-associated infections and antibiotic resistance program;

(b) shall consult with DSPD; and

(c) shall determine whether an alternative placement option is available.

(5) The Department of Health shall deny a request for exemption if funding is not available.

(6) Other eligibility and access requirements in this rule remain in effect.

R414-510-4. Transition Program Access.

(1) Each state fiscal year, the Departments shall identify the number of people projected to participate in the Transition Program.

(2) Based on the funds available for the Transition Program in a given state fiscal year, the Departments shall enroll
individuals into the Waiver through the Transition Program until available funds are exhausted.

(3) In a given state fiscal year, if the funds available for the Transition Program are sufficient to enroll all individuals who have expressed interest in participating in the Transition Program, and meet the requirements in Section R414-510-3, the Departments shall enroll all identified individuals. The Departments shall prioritize community transition to all individuals under 22 years of age.

(4) In a given state fiscal year, if the funds available for the Transition Program are not sufficient to allow transition of all individuals who express interest and who meet the requirements in Section R414-510-3, the Departments shall:

(a) Prioritize community transition to all individuals under 22 years of age;

(b) For individuals over 22 years of age, each interested individual will receive a weighted-score, and be ranked based on that score, from highest to lowest score. Scores shall be based on:

(i) The number of years the person has expressed interest in participating in the Transition Program since State Fiscal Year 2013;

(ii) Whether the applicant has applied for home and community based services and is currently on the DSPD waiting list;

(iii) Length of consecutive stay in an ICF in the state of Utah; and

(iv) If there are multiple individuals with the same weighted-score, the Departments shall rank individuals based on greatest length of stay.

(c) If an individual is selected for the Transition Program and has a spouse who also resides in a Utah ICF and who meets the eligibility criteria in Section R414-510-3, the Departments shall include the spouse in the Transition Program that same year.

(5) Individuals or their guardians will be informed that they can express interest in participating in the Transition Program at any time in writing, or by any other means through which a reasonable person would believe that the individual is interested in living in the community. Interest can be expressed at any time prior to or after state staff make direct contact with the individual or their guardian and the individual retains the right to amend his or her choice at any time.

(6) In cases where an individual does not initially express a choice to transition to the community or to remain in the ICF, the Departments will identify the individual as "undecided." For individuals identified as "undecided," the Departments will engage in additional in-reach and education to build relationships with the individual, the guardian or representative;

(a) After engaging in additional education, the Departments will re-determine whether individuals are interested in moving to the community or continuing to reside in ICFs; and

(b) For remaining individuals who are incapable of expressing choice, the Departments will identify the individuals as "undetermined";

(7) In cases where an individual has been identified as "undetermined," the Departments will utilize a formal assisted decision-making process to support the individual and their guardian to make an informed choice.

R414-510-5. ICF Transition Program Education for Current ICF Residents.

(1) Education about the ICF Transition Program and home and community based services shall be provided by state staff to all individuals residing in ICFs. Education efforts shall be provided on an ongoing basis by state staff and will include, but are not limited to:

(a) Displaying Transition Program and state staff contact information in conspicuous locations within each ICF;

(b) Meeting with individuals living in ICFs, and with their guardians or representatives on a recurring basis;

(c) Providing opportunities for individuals living in ICFs, their guardians or representatives to visit home and community based services settings; and

(d) Providing opportunities for individuals living in ICFs, their guardians or representatives to receive support from peers who have experienced moving from an ICF to home and community based services.

(2) Education about the ICF Transition Program and home and community based services shall be provided in multiple ways and in a manner that is responsive to each person's method of communication. Examples include in-person, one-on-one or group discussions, interactions in community based settings, and communication over the telephone or through email. Educational materials will be provided in print or other mediums.

(3) As ongoing education about community based services is provided to individuals without guardians, state staff will work with the individual and anyone the individual invites to participate. At recurring intervals, state staff will work with the individual and anyone the individual invites to participate to express whether he or she wants to participate in the Transition Program. At each interval, state staff shall document and act upon the individual's decision;

(4) As ongoing education about community based services is provided to individuals with guardians, state staff will work
with the guardian and anyone the guardian invites to participate. State staff will rely on the decision rendered by the guardian regarding whether the guardian wants the individual to participate in the Transition Program.

(5) Individuals or their guardians will be informed that they can express interest in participating in the Transition Program at any time in writing, or by any other means through which a reasonable person would believe that the individual is interested in living in the community. Interest can be expressed at any time prior to or after state staff make direct contact with the individual or their guardian, and the individual retains the right to amend his or her choice at any time.

R414-510-6. Education and Referral for Individuals Seeking ICF Services.

(1) Prior to admission to an ICF, an individual or guardian must contact state staff to receive education of and referral to local resources.

(a) For individuals under 22 years of age, the state agencies shall perform an additional evaluation of services to determine whether community based services are available to assure informed choice before admission to an ICF. The Director of the Division of Medicaid and Health Financing (or designee) and the Director of the Division of Services for People with Disabilities (or designee) shall authorize in writing all ICF admissions of individuals under 22 years of age.

(b) ICFs shall not admit an individual under 22 years of age, unless the admission has been authorized as stated in Subsection R414-510-6(1)(a) above. After admission, the ICF shall keep a copy of the written authorization in the individual's medical record. An individual who admits to an ICF, who meets the requirements described in Section R414-510-3, is eligible to participate in the Transition Program.

(c) Upon completing education and referral with state staff, individuals who are over 22 years of age and decide to move into an ICF, shall be given a written confirmation to demonstrate that the education process occurred prior to admission.

(d) ICFs shall not admit an individual who has not received the required state staff education and referral. After admission, the ICF shall keep a copy of the written confirmation form in the individual's medical record.

(2) Due to an urgent or emergency need, an individual may be admitted to an ICF immediately, and

education and assistance with resources shall be provided after the placement.

(a) The ICF must:

(i) notify the Departments of the admission;

(ii) explain the reason the admission was considered urgent or emergency; and

(iii) provide contact information for the individual, guardian, or representative.

(3) Education shall be provided within 30 days of ICF admission unless an individual's health or other external factors make it necessary to provide the education at a later date.

(4) Once education has been provided, the Departments will provide the ICF with a written confirmation of education form, and the ICF will keep a copy of the form in the individual's medical record.

R414-510-7. Service Coverage.

Services and limitations of the Transition Program may be found in the Waiver State Implementation Plan.

R414-510-8. Reimbursement Methodology.

The Department of Human Services (DHS) contracts with the Department to set rates for waiver-covered services. The DHS rate-setting process is designed to comply with the requirements of Subsection 1915(c) of the Social Security Act and other applicable Medicaid rules. Medicaid requires that rates for services not exceed customary charges.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: May 12, 2021
Notice of Continuation: October 12, 2016
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	R414-320-16	**Filing ID (Office Use Only)**
Changed to Admin. Code Ref. (R no.):		

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
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 person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:
Benefits
3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**
The purpose of this change is to update the maximum adult reimbursement rate for each month, and to clarify provisions for children.
4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**
This amendment allots a new maximum reimbursement amount for adults up to $300 each month, and clarifies coverage and reimbursement for children. It also makes other clarifications and technical changes.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A) State budget:
The Department estimates an aggregate cost of $120,000 to the state budget, with the increase in reimbursement to adult members of Utah's Premium Partnership for Health (UPP) Program.
B) Local governments:
There is no impact on local governments because they neither fund nor determine eligibility for the UPP Program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
Small businesses may see an increase in revenue, but there is no data to estimate what that increase might be.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
Non-small businesses may see an increase in revenue, but there is no data to estimate what that increase might be.

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

Adult members of the UPP program may see an increase in total out-of-pocket savings if the UPP program is able to pay more of their monthly health care premiums.

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

There are no compliance costs as this amendment can only result in out-of-pocket savings to adult members of the UPP program.

G) Comments by the department head on the fiscal impact this rule may have on businesses (Include the name and title of the department head):

There is no measurable impact on business by increasing the premium reimbursement amounts (Nate Checketts, Executive Director).

6. A) 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	**FY2022**	**FY2023**	**FY2024**
State Government	$120,000	$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			
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$120,000	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

B) Department head approval of regulatory impact analysis:

The Executive Director of the Department of Health, Nate Checketts, has reviewed and approved this fiscal analysis.

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 26-1-5	Section 26-18-3	

Incorporations by Reference Information

(If this rule incorporates more than two items by reference, please include additional tables.)

8. 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*)**:**

	First Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
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*)**:**	
	Second Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
Issue, or version	

Public Notice Information

9. 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 (mm/dd/yyyy)**:**		12/01/2021
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

10. This rule change MAY become effective on (mm/dd/yyyy)**:**	12/08/2021
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date. To make this rule effective, the agency must submit a Notice of Effective Date to the Office of Administrative Rules on or before the date designated in Box 10.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee, and title:	Nate Checketts, Executive Director	**Date** (mm/dd/yyyy)**:**	10/11/2021

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-320. Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver.
R414-320-16. Benefits.

(1) The UPP program shall provide enrollees a monthly reimbursement payment for health coverage[~~cash reimbursement to enrollees~~].

(2) The reimbursement may not exceed the amount that the enrollee pays toward the cost of the employer-sponsored health plan, [~~employer-sponsored plans selected through UHE,~~]or COBRA continuation coverage.

(3) The UPP program shall[~~may~~] reimburse [~~an adult~~]up to [~~$150~~]$300 monthly for each eligible adult[~~each month~~].

(4) The UPP program shall[~~may~~] reimburse [~~a child~~]up to $120 for each eligible child's[~~-month for~~]medical coverage. [~~The UPP program will pay the child an additional $20 if the child elects to enroll in employer-sponsored dental coverage.~~]

(a) When the employer-sponsored insurance does not include dental benefits, a child [~~may~~]shall receive [~~cash reimbursement up to $120 for the medical insurance cost and may receive~~]dental-only benefits through CHIP in addition to the medical insurance reimbursement.

(b) When the employer also offers employer-sponsored dental coverage, the applicant may choose to enroll a child in the employer-sponsored dental coverage, in which case, the UPP program will include[pay the child] an additional $20 for each eligible child enrolled. [The enrollee may also choose to only enroll the child in the employer-sponsored health insurance and UPP, and not enroll the child in the employer-sponsored dental coverage, in which case the child may receive dental-only benefits through CHIP.]

KEY: CHIP, Medicaid, PCN, UPP
Date of Enactment or Last Substantive Amendment: September 16, 2020
Notice of Continuation: January 25, 2021
Authorizing, and Implemented or Interpreted Law: 26-18-3; 26-1-5

State of Utah
Administrative Rule Analysis
Revised June 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-10**	**Filing ID: (Office Use Only)**

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
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 person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Physician Services
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules while Section 26-1-5 authorizes the Department to adopt rules as necessary for program implementation. 42 CFR 440.50 also allows the Department to provide physician services to Medicaid members who fall within a physician's scope of practice.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it sets forth eligibility requirements, requirements for program access, and provisions for coverage. The Department recently amended this rule to update the scope of practice for physician assistants set forth in Title 58, Chapter 70a, and to make other clarifications.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee, and title:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	10/18/2021
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-10. Physician Services.
R414-10-1. Introduction and Authority.

(1) The Physician Services Program provides a scope of physician services to meet the basic medical needs of eligible Medicaid members. It encompasses the art and science of caring for those who are ill through the practice of medicine or osteopathy defined in Title 58, Occupations and Professions.

(2) Physician services are a mandatory Medicaid program authorized by Section 1901 of the Social Security Act, Subsections 1861(q)(r) and 1905(a)(5)(6) of the Social Security Act, and Sections 26-1-5 and 26-18-3.

R414-10-2. Definitions.
In addition to the definitions in Rule R414-1, the following definitions apply to this rule:
(1) "Family planning" means diagnosis, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy.
(2) "Global surgical procedures" means preoperative office visits and preparation, the operation itself, local infiltration, topical or regional anesthesia when used, and normal follow-up care.
(3) "Physician services", whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services performed by a Medicaid provider that meet the following standards:
(a) Services are performed within the scope of the physician's license as defined in Title 58, Occupations and Professions;
(b) Services are performed by a doctor of medicine or osteopathy, a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, a chiropractor, or;
(c) Services include medical care, or any other type of remedial care furnished by licensed practitioners.
(4) "Practice as a physician assistant" means:
(a) acting as an agent of the supervising physician, and when under the authority of a substitute supervising physician, acting in accordance with a delegation of services agreement; and
(b) performing professional duties within the conduct of a physician assistant in diagnosing, treating, advising, or prescribing for any human disease, ailment, injury, infirmity, deformity, pain, or other condition.
(5) "Services" means the types of medical assistance specified in Subsection 1905(a) of the Social Security Act and interpreted in 42 CFR 440.

R414-10-3. Member Eligibility Requirements.
Physician services are available to categorically and medically needy eligible individuals.

R414-10-4. Program Access Requirements.
(1) An eligible Medicaid member may obtain physician services from any Utah Medicaid provider.
(2) An individual who does not meet United States residency requirements may only receive emergency services, including emergency labor and delivery, to treat an emergency medical condition, as stated in Section R414-1-7.
(a) Medicaid does not cover prenatal and post-partum services for undocumented immigrants.

R414-10-5. Service Coverage and Limitations.
(1) General Information.
(a) Physician services may be provided only within the parameters of accepted medical practice and are subject to limitations and exclusions established by the Department on the basis of medical necessity, appropriateness, and utilization control considerations.
(b) Cosmetic or reconstructive procedures, see Section R414-1-29.
(c) Experimental or medically unproven physician services, see Rule R414-1A.
(d) Program limitations and non-covered services are maintained in the Coverage and Reimbursement Code Lookup and updated by notification through the Medicaid Information Bulletin. Medicaid does not cover the following types of services:
(i) Services rendered during a period in which an individual is ineligible for Medicaid;
(ii) Medically unnecessary or unreasonable services;
(iii) Services that fail to meet existing standards of professional practice;
(iv) Services rendered without required prior authorization;
(v) Services, elective in nature, based on patient request or individual preference rather than medical necessity;
(vi) Services claimed fraudulently;
(vii) Services that represent abuse or overuse;
(viii) Services rejected or disallowed by Medicare when the rejection is based on any of the reasons listed in Section R414-10-5;

(ix) Services for which third-party payers are primarily responsible for coverage, such as Medicare, private health insurance, and liability insurance pursuant to Rule R527-936. Medicaid may make a partial payment up to the Medicaid maximum if a third party does not reach the payment limit;

(x) Related services, supplies, or institutional costs during a post-operative recovery period, if the service or procedure is not covered for any of the reasons specified in Section R414-10-5, or due to policy exclusion; and

(xi) Paternity tests.

(e) Alcoholism or drug dependency in an inpatient setting, see Subsection R414-2A-7(2).

(f) A physician assistant who works under the supervision of physician, or as a staff member of a facility, is not an independent practitioner and cannot bill independently.

(i) Service limitations or exclusions that apply to a physician shall also apply to the physician assistant.

(ii) Only a licensed physician may perform the specialty medical services of an assistant surgeon that include complex surgical procedures, while a physician assistant may neither perform specialty medical services nor assist in a surgical procedure.

(iii) Medicaid, as it considers necessary, may apply exceptions to the duties of a supervised-physician assistant in rural areas or in federally-designated health professional shortage areas.

(2) Family Planning Services.

(a) Medicaid does not cover the following family planning services:

(i) Surgical procedures for the reversal of previous elective sterilization on both males and females;

(ii) Infertility studies;

(iii) In vitro fertilization;

(iv) Artificial Insemination; and

(v) Surrogate motherhood, including all services, tests, and related charges.

(3) Anesthesia.

(a) Medicaid may only cover anesthesia services performed by a licensed, qualified provider.

(b) Medicaid does not cover anesthesia standby services.

(4) Surgical Services.

(a) Surgical procedures.

(i) Surgical services are global services. Global services include:

(b) preoperative examination, initiation of the hospital record, and development of a treatment program either in the physician's office on the day before admission, or in the hospital or the physician's office on the same day as hospital admission;

(c) the operation;

(d) any topical, local, or regional anesthesia; and

(e) the normal, uncomplicated follow-up care covering the period of hospitalization and office follow-up for progress checks or any service directly related to the surgical procedure.

(f) Interpretation of "global" services:

(i) A physician may not bill for an office visit the day before surgery, for preadmission or admission workup, or for subsequent hospital care while the patient is being prepared, hospitalized, or under care for a "global" surgical service;

(ii) Only the consulting physician may bill for consultation services when consultation and no other service is provided. When a consulting physician admits and follows a patient, independently or concurrently with the primary physician, the consulting physician may only use admission codes and subsequent care codes;

(iii) Office visits after hospitalization that relate to the same diagnosis are part of the global service. The only exception to either inpatient or office service is for service related to complications, exacerbations, or recurrence of other diseases or problems requiring additional or separate service.

(iv) Complications, exacerbations, recurrence, or the presence of other diseases or injuries, which require services concurrent with the initial surgical procedure during the listed period of normal follow-up care, may warrant additional charges only when the record shows extensive documentation and justification of additional services.

(v) When an additional surgical procedure is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods continue concurrently to their normal terminations.

(vi) Preoperative examination and planning are covered as separate services only under the following circumstances:

(I) When the preoperative visit is the initial visit for the physician and prolonged detention or evaluation is required to establish a diagnosis to determine the need for a specific surgical procedure, or to prepare the patient;

(II) When the preoperative visit is a consultation and the consulting physician does not assume care of the patient; or

(III) When diagnostic procedures are not part of the basic surgical procedure.

(5) Maternity Care and Delivery.

(i) Medicaid does not cover early elective delivery, whether vaginal or caesarean, before 39 weeks.

(6) Abortion, Sterilization and Hysterectomy.

(i) For information on abortion policy, see Rule R414-1B.

(ii) Sterilization and hysterectomy procedures must meet the requirements of 42 CFR 441, Subpart F.

(7) Transplant Services.

(i) Organ transplant services must meet the requirements of Rule R414-10A.

(8) Medicine.

(a) Psychiatric Services. The following services may be covered as a medical benefit:

(i) Physician-ordered psychiatric services for a patient hospitalized in a non-psychiatric unit of a hospital;

(ii) Mental health services that target the diagnosis or treatment of developmental disability or organic disorder; and

(iii) Psychosocial evaluations requested before organ transplantations, psychiatric evaluations before other medical services or surgical procedures, and evaluations for individuals with conditions that require chronic pain management services.

(b) Pain Management Services.

(i) Medicaid covers pain management for delivery and acute postoperative pain.

(ii) Medicaid covers treatment for chronic pain.

(c) Medications.

(i) Medicaid may cover prescription medications subject to the requirements of Rule R414-60.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: July 1, 2017
Notice of Continuation: October 24, 2016
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2021

NOTICE OF EMERGENCY (120-DAY) RULE		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R414-524**	**Filing ID: (Office Use Only)**

Agency Information

1. Department:	Department of Health
Agency:	Division of Medicaid and Health Financing
Room no.:	
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 person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov

Please address questions regarding information on this notice to the agency.

General Information

2. Rule or section catchline:

American Rescue Plan Act, Home and Community-Based Services Enhanced Funding

3. Effective Date (mm/dd/yyyy)**:**

10/29/2021

4. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The purpose of this rule is to implement Section 9817 of the American Rescue Plan Act of 2021 (ARPA), to assist providers of home and community-based services (HCBS).

5. Summary of the new rule or change (What does this filing do?)**:**

This rule enacts supplemental payments to HCBS providers, as allowed under ARPA, to provide economic relief to businesses affected by the Coronavirus (COVID-19) pandemic.

6. A) The agency finds that regular rulemaking would:	
X	cause an imminent peril to the public health, safety, or welfare;
X	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:

This emergency rule is needed to provide economic relief to HCBS providers and businesses affected by the COVID-19 pandemic.

Fiscal Information

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

A) State budget:

The Department expects annual costs to be about $9,996,378 during the public health emergency period.

B) Local governments:

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

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

Small businesses may see a share of $9,996,378 in supplemental payments during the public health emergency period.

D) 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***)**:**

HCBS providers may see a share of $9,996,378 in supplemental payments during the public health emergency period.
E) 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 rule only supplements business revenue and increases access to services.
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):
Businesses may receive supplemental payments to mitigate lost revenue incurred during the public health emergency period (Nate Checketts, Executive Director).

Citation Information

8. 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 26-1-5	Section 26-18-3	Pub. L. No. 117-2

Incorporations by Reference Information

(If this rule incorporates more than two items by reference, please include additional tables)

9. 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*)**:**	
	First Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
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*)**:**	
	Second Incorporation
Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
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:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	10/15/2021

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

R414-524. American Rescue Plan Act, Home and Community-Based Services Enhanced Funding.

R414-524-1. Introduction and Authority.

(1) This rule enacts supplemental payments to eligible providers as authorized under the American Rescue Plan Act of 2021 (ARPA), Pub. L. No. 117 2, Sec. 9817.

(2) This rule is authorized under Attachment 4.19-B of the Utah Medicaid State Plan, Utah's approved home and community-based services (HCBS) waiver implementation plans, and by Sections 26-1-5 and 26-18-3.

R414-524-2. Program Eligibility.

(1) Eligible billing providers include providers who bill for services provided under Utah's approved 1915(c) HCBS waivers, and for services delivered through both traditional and self-administered service provider arrangements.

(2) State plan services delivered through fee-for-service or managed-care payment arrangements include the following:

(a) home health services;

(b) private duty nursing for in-home services only;

(c) hospice services for in-home services only;

(d) personal care services;

(e) case management;

(f) school-based services;

(g) rehabilitative services for outpatient mental health and substance use treatment services; and

(h) early and periodic screening, diagnostic, and treatment for autism spectrum disorder-related services.

(3) Eligible services include services approved by the Centers for Medicare and Medicaid Services for the HCBS Enhanced Funding Spending Plan.

R414-524-3. Program Access Requirements.

(1) In order to qualify for this supplemental payment, eligible billing providers must complete an attestation of the following:

(a) an understanding that these are time-limited payments;

(b) an agreement that providers use a portion of the funds to address direct-care worker issues; and

(c) an agreement that providers use funds to expand, enhance, or strengthen HCBS or other applicable services authorized under ARPA Section 9817.

(2) A provider's attestation applies until the end of the program or until the provider's attestation is rescinded in writing.

(3) If a provider makes an attestation no later than March 31, 2022, the attestation becomes effective retroactively to April 1, 2021.

(4) An attestation provided in any subsequent quarter is effective only back to the first day of the quarter in which the attestation is made.

R414-524-4. Payments.

(1) The Department makes time-limited quarterly supplemental payments to eligible providers for the period authorized under ARPA, April 1, 2021, through March 31, 2024.

(2) An eligible provider's completed attestation allows the first and subsequent supplemental payment calculations.

(3) Payments are calculated based on the methodology described in the Utah Medicaid State Plan and 1915(c) waiver implementation plans.

KEY: Medicaid
Date of Last Change: New
Notice of Continuation: New
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New ___; Amendment ___; Repeal ___; Repeal and Reenact X___		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R414-516**	**Filing ID 54080**

Agency Information

1. Department:	Health	
Agency:	Health Care Financing, Coverage and Reimbursement Policy	
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 person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:
Nursing Facility Non-State Government-Owned Upper Payment Limit Quality Improvement Program
3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**
The purpose of this rule is to define participation requirements for the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program.
4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**
Some requirements of the repealed rule are reenacted in the proposed rule. In contrast to the repealed rule, the proposed rule focuses mainly on QI participation requirements, and does not include provisions for quality awards, construction, renovation, quality metrics, and staffing. The proposed rule also includes new definitions and new provisions for exceptions and holdings.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A) State budget:
There is no impact to the state budget as this reenactment does not affect previous funding for the QI program.
B) Local governments:
There is no impact on local governments as this reenactment does not affect previous funding for the QI program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no impact on small businesses as this reenactment does not affect previous funding for the QI program.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
There is no impact on non-small businesses as this reenactment does not affect does not affect previous funding for the QI 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***)**:**
There is no impact on Medicaid providers and Medicaid members as this reenactment does not affect previous funding for the QI 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 reenactment does not affect previous funding for the QI program.
G) Comments by the department head on the fiscal impact this rule may have on businesses (Include the name and title

of the department head):
Businesses will see neither costs nor revenue as this change does not previous funding for the QI program. Nate Checketts, Executive Director.

6. A) 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	**FY2022**	**FY2023**	**FY2024**
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			
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**

B) Department head approval of regulatory impact analysis:

The Executive Director of the Department of Health, Nate Checketts, has reviewed and approved this fiscal analysis.

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 26-1-5	Section 26-18-3	

Public Notice Information

9. 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 (mm/dd/yyyy)**:**	12/15/2021

10. This rule change MAY become effective on (mm/dd/yyyy)**:**	12/22/2021

NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date. To make this rule effective, the agency must submit a Notice of Effective Date to the Office of Administrative Rules on or before the date designated in Box 10.

Agency Authorization Information

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

Agency head or designee, and title:	Nate Checketts, Executive Director	**Date** (mm/dd/yyyy)**:**	11/01/2021

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

R414-516. Nursing Facility Non-State Government-Owned Upper Payment Limit Quality Improvement Program.

[~~**R414-516-1. Introduction and Authority.**~~

~~This rule defines the participation requirements for the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program. This rule applies~~

only to nursing facility providers who are part of a contract with the Department to participate in the NF NSGO UPL program. This rule is authorized by Sections 26-1-5 and 26-18-3.

R414-516-2. Definitions.

The definitions in Rule R414-505 apply to this rule. In addition:

(1) "American Health Care Association (AHCA)" means the national association of long term and post-acute providers for quality care and services for frail, elderly, and disabled Americans.

(2) "Certification And Survey Provider Enhanced Reports (CASPER)" means a quality measure report used by the Centers for Medicare and Medicaid Services (CMS) to compare data between nursing facility programs.

(3) "Certified Nurse Aid (CNA)" means any person who completes a nurse aid training and competency evaluation program (NATCEP) and passes the state certification examination.

(4) "Division" means the Division of Medicaid and Health Financing (DMHF).

(5) "Eden Certification" means a program achieving Eden Milestones as approved by the Eden Alternative organization.

(6) "Fair Rental Value (FRV)" means the definition provided in Attachment 4.19-D of the Medicaid State Plan.

(7) "Five-Star Quality Rating System" means a rating system developed by CMS to help consumers, their families, and other caregivers compare health inspection reports, staffing, and quality measures (QM) between nursing programs.

(8) "Nurse" means an individual who is licensed under Title 58, Chapter 31b as:

(a) a licensed practical nurse (LPN);

(b) a registered nurse (RN);

(c) an advanced practice registered nurse (APRN); or

(d) a nurse practitioner (NP).

(9) "Program" means each distinct NF program participating in the NF NSGO UPL program.

(10) "Qualified Activity Professional" means:

(a) a qualified therapeutic recreation specialist or an activities professional who is licensed or registered in the state of Utah;

(b) an activities professional who is recognized by an accrediting body;

(c) a person who has two years of experience in a social or recreational program within the last five years, one year of which was full-time in a therapeutic activities program;

(d) an occupational therapist (OT); or

(e) an occupational therapy assistant (OTA).

(11) "Qualified Clinician" means:

(a) a physician;

(b) a surgeon;

(c) a chiropractic physician;

(d) a physician assistant;

(e) a physical therapist;

(f) a physical therapist assistant;

(g) an OT; or

(h) an OTA.

(12) "Resident" means a Utah Medicaid eligible individual who resides in and receives nursing facility services in a Utah Medicaid-certified nursing facility.

R414-516-3. Quality Improvement Program Requirements of Participation.

(1) A program is required to earn quality improvement (QI) points to participate in the NF NSGO UPL Program. A program shall earn and document:

(a) In Calendar Year 2018, 10 or more QI points with a minimum of five QI points from Section R414-516-6;

(b) In Calendar Year 2019, 12 or more QI points with a minimum of six QI points from Section R414-516-6;

~~(c) In Calendar Year 2020 and beyond, 14 or more QI points with a minimum of seven from Section R414-516-6.~~

~~(2) QI points may be earned from any combination of the QI Program Categories as long as the minimum number of QI points are earned from Section R414-516-6.~~

~~(3) When calculating compliance under Section R414-516-6, a program shall not count residents who are in the facility less than 14 days.~~

~~(4)(a) Each program shall submit to the Division a compliance form, using the current Division form, on or before January 31 following the end of the calendar year, documenting that the program qualifies to earn points under the selected QI program categories.~~

~~(b) A compliance form must be mailed or electronically mailed to the correct address found at https://health.utah.gov/stplan/longtermcarenfqi.htm.~~

~~(c) In all cases, no additional compliance forms, documentation, unless requested as part of an audit, or explanation will be accepted if submitted after the annual submission deadline.~~

~~(d) Any program that does not submit its compliance form by the deadline shall receive zero points for that program year.~~

~~(5) The Division does not require a provider that enters the NF NSGO UPL program for only part of a calendar year, based on provider participation start date, to comply with the QI provisions of Section R414-516-3 in the first program calendar year.~~

~~R414-516-4. Quality Awards.~~

~~(1) A program may earn QI points through achieving the following quality awards, certifications, and ratings:~~

~~(2) The AHCA National Quality Award;~~

~~(a) A program that has earned the Gold AHCA quality award may earn six QI points for the duration of the award;~~

~~(b) A program that has earned the Silver AHCA quality award may earn four QI points for the duration of the award;~~

~~(c) A program that has earned the Bronze AHCA quality award may earn two QI points for the duration of the award.~~

~~(3) The HealthInsight Quality Award;~~

~~(a) A program that has earned a HealthInsight Quality Award may earn two QI points for the year awarded.~~

~~(4) Eden Certification Milestones; and~~

~~(a) A program that achieves an Eden Certification Milestone at the time of implementation of this rule may receive QI points in the same formula for a program achieving the initial milestone;~~

~~(b) A program may earn, in the initial year of the achievement, one QI point for achieving milestone one;~~

~~(c) A program may earn, in the initial year of the achievement, three QI points for achieving milestone two and two QI points the following year;~~

~~(d) A program may earn, in the initial year of the achievement, five QI points for achieving milestone three, three QI points the following year, and two QI points the third year.~~

~~R414-516-5. Construction and Renovation.~~

~~A program may earn up to seven QI points by constructing or renovating its physical facility or increasing access to care by providing services in a rural county as follows:~~

~~(1) Constructing or renovating its physical facility:~~

~~(a) A program may earn seven QI points for having a FRV facility age of eight years or less;~~

~~(b) A program may earn five QI points for having a FRV facility age of fifteen years or less;~~

~~(c) A program may earn up to four QI points for using a percentage of UPL monies on facility renovations. The percentage is calculated by dividing the monies spent on a major renovation, replacement beds, or additional beds as reported in the program's audited FRV Data Report as described in the Attachment 4.19-D of the Medicaid State Plan, (numerator) by the amount of NF NSGO UPL monies paid in the same period as the FRV Data Reported renovation project (denominator).~~

~~(i) A program may earn four QI points for using greater than 75 percent of UPL monies.~~

~~(ii) A program may earn two QI points for using greater than 50 percent of UPL monies.~~

~~(2) Access to care by providing services to Medicaid members in a rural county.~~

~~(a) A program located in a county other than Cache, Davis, Salt Lake, Utah, Washington, or Weber may receive one QI point.~~

~~(b) A program located in an area where no other Utah Medicaid-certified nursing facility is within a 35-mile radius may receive one QI point.~~

~~R414-516-6. Direct Resident Services.~~

~~(1) A program may earn QI points by providing the following direct resident services. "Resident" means the same as that term is defined in Section R414-516-2:~~

~~(a) The program may earn one QI point by providing a denture-replacement policy in which the program will replace lost or damaged dentures for a resident within 90 days of the loss or damage.~~

~~(b) The program may earn up to three QI points for dining service options provided in the categories below:~~

~~(i) The program may earn one QI point by providing a menu option of at least five meal choices outside of the planned meal;~~

~~(ii) The program may earn one QI point by providing a cook-to-order menu;~~

~~(iii) The program may earn three QI points by providing a five-meal program for the entire calendar year; or~~

~~(iv) The program may earn one QI point by providing a four-meal program for the entire calendar year.~~

~~(3) The program may earn two QI points through a preferred-snack program that shows 80% compliance in providing resident preferences.~~

~~(a) The program shall provide a snack survey that includes food and beverage options, snack-time options, the date of the survey, and the name of the person who completes the survey.~~

~~(b) The program shall complete the survey within two weeks of the admission date.~~

~~(c) The program shall provide the snack and beverage at each resident's preferred time.~~

~~(d) If a resident requires feeding assistance, the facility shall provide a dining assistant during the snack.~~

~~(e) The program shall complete a snack survey quarterly for each resident or as requested by the resident.~~

~~(f) The program shall calculate compliance by dividing the number of residents who complete a preferred snack survey (numerator) by the number of residents during the quarter, who desired to complete a snack survey (denominator).~~

~~(4) The program may earn two QI points through a preferred-bedtime program that shows 80% compliance in providing resident preferences for bedtime.~~

~~(a) The program shall provide a bedtime survey, in which the resident is asked about preferred-bedtime options and preferred rituals. The program must include the date of the survey and the name of the person who completes it.~~

~~(b) The program shall complete the survey within two weeks of the admission date.~~

~~(c) The program shall provide each resident the resident's preferred bedtime options and preferred rituals.~~

~~(d) The program shall complete a bedtime survey annually or as requested by the resident.~~

~~(e) The program shall calculate compliance by dividing the number of residents who complete a bedtime survey (numerator) by the number of residents during the calendar year, subtracted by the residents who declined to complete a bedtime survey (difference is denominator).~~

~~(5) The program may earn up to five QI points by providing consistent CNA or nursingstaff assignments to residents that show 80% compliance in providing consistent CNA or nursing staff assignments. The program may earn points by providing the same CNA or nurse for a resident for 32 waking hours during a standard Sunday through Saturday week.~~

~~(a) The program may earn one QI point for having a staffing schedule that provides consistent CNAs and nurses for the entire program.~~

~~(b) The program may earn one QI point by providing consistent CNA assignment to a distinct hall containing at least 10 residents.~~

~~(c) The program may earn two QI points by providing consistent CNA assignment to an entire program.~~

~~(d) The program may earn one point by providing consistent nurse assignment to a hall that contains at least 10 residents.~~

~~(e) The program may earn two QI points by providing consistent nurse assignment to an entire program.~~

~~(f) The program shall provide the consistent CNA or nursing staff assignment for 40 of 52 weeks during the calendar year.~~

~~(g) The program shall calculate compliance by dividing the number of residents who receive consistent CNA or nursing staff assignment in the hall or program (numerator) by the number of residents during the calendar year in the hall or program (denominator).~~

~~(6) The program may earn four QI points by providing a range of motion (ROM) program semi-annually to residents through a qualified clinician; or, may earn two QI points by providing a ROM program semi-annually to residents through a restorative nurse aid under the direct supervision of a qualified clinician. The program must show 80% compliance to a ROM program.~~

~~(a) The program shall include a ROM assessment, completed by a qualified clinician, for passive range of motion (PROM) or active range of motion (AROM) for shoulder, elbow, wrist, digits of the hand, hip, knee, and ankle joints. The program shall also include a ROM assessment of any joint with a limitation, the reduced anatomical motion to the joint, how the restriction limits function, the job title and name of the person who completes the plan of care (POC), and the date of the POC.~~

~~(b) If the clinician finds a reduction in ROM and recommends a ROM POC, the POC must include:~~

~~(i) a goal to return the resident to the highest practicable level of function;~~

~~(ii) the frequency and duration of the POC;~~

~~(iii) the title and name of the qualified clinician or restorative nurse aid who completes the POC; and~~

~~(iv) the date of the POC.~~

~~(c) If a qualified clinician develops a POC for a resident, a qualified clinician or restorative nurse aid shall complete the POC under the supervision of a qualified clinician.~~

~~(d) If a resident qualifies for a ROM POC, but desires not to participate, the qualified clinician shall document the refusal and provide a ROM assessment semi-annually.~~

~~(e) The program shall calculate compliance by dividing the number of residents who receive a ROM assessment semi-annually plus the number of residents who refuse to complete a ROM assessment semi-annually (sum is numerator) by the number of residents during the calendar year (denominator).~~

~~(7) The program may earn up to four QI points by providing a one-on-one activity program. The one-on-one activity program shall provide at least a 30-minute individual activity onsite or within the community each month for each resident.~~

~~(a) The program may earn one QI point by providing a schedule for one-on-one activity participation for residents who desire to participate.~~

~~(b) The program may earn three QI points if it provides one-on-one activities.~~

~~(c) A qualified activity professional shall complete an activity interest (AI) survey for each resident that includes recreational, educational, physical, arts and crafts, and any additional activity options preferred by the resident. The AI survey shall include the name and job title of the person who completes the survey and the date the survey is completed.~~

~~(d) The following provisions are required to each resident who desires to participate in a one-on-one activity program:~~

~~(e) A qualified activity professional shall develop a POC that includes the preferred list of activities and a method of ranking the importance of the activities to the resident. The activity POC must include:~~

~~(i) the activities to be completed during the one-on-one activity;~~

~~(ii) the goal of the activity;~~

~~(iii) what the activity is promoting;~~

~~(iv) the date the POC was completed; and~~

~~(v) the job title and name of the person who completes the POC.~~

~~(f) The person who completes the activity with the resident shall document:~~

~~(i) the preferred activity completed;~~

~~(ii) the duration of the activity;~~

~~(iii) the goal of the activity;~~

~~(iv) which quality of life measures were promoted; and~~

~~(v) any relevant comments made by the resident.~~

~~(g) The qualified activity professional shall modify the POC as appropriate or when requested by the resident.~~

~~(h) If a resident who desires to participate in the one-on-one activity program cannot participate in a given month, the program shall document the refusal.~~

~~(i) If a resident refuses to participate in the one-on-one activity program, the qualified activity professional shall document the refusal and continue to complete an AI survey with the resident, and offer the one-on-one activity program annually.~~

~~(j) If a resident initially refuses to participate in the one-on-one activity program and desires to participate before the annual AI survey, the qualified activity professional shall complete the steps noted for residents desiring to participate in a one-on-one activity program.~~

~~(k) The program shall calculate compliance by adding the number of residents who participated in but declined a monthly one-on-one activity, the number of residents who completed the program, and the number of residents who declined to complete the program (distinct sum is numerator) divided by the number of residents during the calendar year (denominator).~~

~~(8) The program may earn four QI points by providing a mobility program to qualifying residents that shows 80% compliance in a mobility program. The program shall offer residents who qualify for a walking program a walking activity five of seven days in a standard week for 40 out of 52 weeks during the calendar year.~~

~~(a) A nurse or qualified clinician shall complete Section GG0170 Mobility of the Minimum Data Set Version 3.0 for each resident.~~

~~(b) A resident who achieves a score of 04, 05, or 06 on sections D and J qualifies to participate in a walking program.~~

~~(c) The nurse or qualified clinician who completes the mobility section shall establish a POC for the walking program to determine:~~

~~(i) the distance of the walk;~~

~~(ii) duration of the walk; and~~

~~(iii) the amount of assistance required by a resident, including mobility devices to be provided by the staff.~~

~~(d) The program shall provide weekly documentation to illustrate program completion, including any modification to a resident's walking program.~~

~~(e) If a resident qualifies for, but refuses to participate in the walking program, the nurse or qualified clinician shall document the refusal and complete the survey annually.~~

~~(f) If a resident initially declines to participate in the walking program and then requests to engage in the walking program before the annual follow-up survey, the nurse or qualified clinician shall complete the survey and develop a walking POC for the resident.~~

~~(g) The program shall calculate compliance by adding the number of residents who completed the walking program with the residents who qualified for, but requested limited participation in the program. The program shall also add the number of residents who qualified for, but declined participation in the walking program (distinct sum is numerator) by the number of residents who qualified for a walking program during the calendar year (denominator).~~

~~R414-516-7. Quality Metrics.~~

~~(1) A program may earn up to six QI points for demonstrating quality metric scores equal to or better than the industry average noted.~~

~~(a) The industry average used to calculate the QI points for Subsections R414-516-7(b) and (c) are determined in accordance with the following data:~~

~~(i) CMS 5-Star quality measure rating, for long-stay residents, obtained from CMS online data sources. The industry average is 3.62. To qualify, the program must equal or exceed the industry average;~~

~~(ii) CASPER Quality Measures for urinary tract infections obtained from CMS online data sources. The industry average is 6.68%. To qualify, the program must have less than or equal to the industry average;~~

~~(iii) CASPER Quality Measures for pressure ulcers obtained from CMS online data sources. The industry average is 6.15%. To qualify, the program must have less than or equal to the industry average;~~

~~(iv) CASPER Quality Measures for falls with a major injury obtained from CMS online data sources. The industry average is 4.17%. To qualify, the program must have less than or equal to the industry average;~~

~~(v) Nurse staffing hours per resident day obtained from CMS online data sources. The industry average is 3.81. To qualify, the program must equal or exceed the industry average; or~~

~~(vi) Survey deficiency scope and severity obtained from the Utah Bureau of Licensing and Certification. The industry average is 3.57. To qualify, the nursing facility program must have less than or equal to the industry average.~~

~~(b) The program may earn QI points as follows:~~

~~(i) The program may earn four QI points by achieving metrics scores equal to or superior to the industry average in greater than four of six targets;~~

~~(ii) The program may earn three QI points by achieving metrics scores equal to or superior to the industry average in four of six targets; or~~

~~(iii) The program may earn two QI points by achieving metrics scores equal to or superior to the industry average in three of six targets.~~

~~(c) The program may earn QI points from demonstrating metrics score improvement as follows:~~

~~(i) The program may earn two QI points by demonstrating metrics score improvement in greater than four of six targets; or~~

~~(ii) The program may earn one QI point by demonstrating metrics score improvement in four of six targets.~~

~~(2) The program may earn one QI point by demonstrating a 20% improvement in two specific quality metrics scores on the CASPER report at the end of the 12-month data, October through September, period as compared to the prior 12-month data period.~~

~~R414-516-8. Staffing.~~

~~(1) A program may earn up to four QI points for providing employee retention programs in the categories below:~~

~~(a) A program may earn one QI point by offering health insurance to all full-time employees;~~

~~(b) A program may earn one QI point by demonstrating improved staff retention of 20% facility wide compared to the previous calendar year. The program shall calculate staff retention by dividing the number of staff who separated from the program during the calendar year (numerator) by the number of all staff employed during the calendar year (denominator), and subtracting the retention percentage of the previous calendar year from the retention percentage of the current calendar year;~~

~~(c) A program may earn two QI points by demonstrating a staff turnover rate below 50% during the calendar year. The program shall calculate turnover rate by dividing the number of distinct staff who separated from the program during the calendar year (numerator) by the number of all distinct staff employed during the calendar year (denominator).~~

~~(d) A program may earn one QI point by offering:~~

~~(i) a 401K plan that includes an employer contribution; or~~

~~(ii) a pension or retirement program.~~

~~(e) A program may earn one QI point by:~~

~~(i) providing tuition reimbursement for formal education;~~

~~(ii) providing reimbursement for continuing education; or~~

~~(iii) providing reimbursement for certification courses.~~

~~(2) Providing staff training. A program may earn one QI point by providing staff training through a nursing facility industry-recognized source using virtual or onsite resources.~~

~~R414-516-9. Exceptions and Holdings.~~

~~(1) A program that does not earn the minimum required QI points during a calendar year shall:~~

~~(a) earn the number of QI points not achieved from that calendar year in addition to the required QI points the subsequent calendar year; and~~

~~(b) submit to the Division a plan of correction that details how the program will come into compliance with the QI Program.~~

~~(c) The program must mail electronically a plan of correction to the correct address found at https://health.utah.gov/stplan/longtermcarenfqi.htm.~~

~~(2) The Division shall remove from the UPL Seed Contract, a program that fails to earn the minimum QI points for a second consecutive year as in accordance with Subsection R414-516-9(1)(a).~~

~~(a) Once the Division determines that the program failed to meet QI program qualifications, the Division shall send the program a notice of failure to meet the requirements.~~

~~(b) The program shall have the opportunity to appeal the determination in accordance with Rule R410-14, or shall waive the right of appeal.~~

~~(c) If the program does not file an appeal or the Division upholds its determination, the Division shall amend the UPL seed contract to remove the program effective the last day of the quarter in which the determination is made.~~

~~(3) If a program that has been removed from the UPL Seed Contract desires to be added back to the contract prospectively, the program shall demonstrate compliance in accordance with Subsection R414-516-3(1)(c) for one full year, "trial period", after the effective date of the removal.~~

~~(a) The program shall submit the following to the Division within 30 days of the trial period:~~

~~(i) the current compliance form completed; and~~

~~(ii) documentation of compliance with all QI programs in which points were earned.~~

~~(b) If the Division determines that the program was compliant during the trial period, the Division may include the program in the UPL Seed Contract effective the first day of the quarter following the date compliance was determined.~~

~~(4) The Division may audit a program at any time to ensure compliance.~~

~~(a) The Division shall provide notice that indicates the period of the audit and the QI programs being audited.~~

~~(b) When an audit is performed, all documentation requested by the Division shall be postmarked or demonstrate proof of delivery to the Division within 30 calendar days of the request.~~

~~(c) Failure to submit the requested documentation within 30 calendar days, shall result in the program forfeiting the QI points for the specific QI program category being audited.~~

~~(d) Audit results shall supersede the program's reported QI points.~~

~~(e) The program shall have the opportunity to appeal the determination in accordance with Rule R410-14, or shall waive the right of appeal.~~]

R414-516-1. Introduction and Authority.

This rule defines participation requirements for the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program. This rule applies only to nursing facility providers who are part of a contract with the Department to participate in the NF NSGO UPL program. This rule is authorized by Sections 26-1-5 and 26-18-3.

R414-516-2. Definitions.

The definitions in Rule R414-505 apply to this rule. The following definitions also apply.

(1) "Certification and survey provider enhanced reports (CASPER)" means a quality measure report used by the Centers for Medicare and Medicaid Services (CMS) to compare data between nursing facility programs.

(2) "Program" means the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program.

(3) "Resident" means a Medicaid patient who resides in and receives nursing facility services in a Medicaid-certified nursing facility.

(4) "Seed contract" means a contract between the Division of Medicaid and Health Financing (DMHF) and a non-state government entity to participate in the upper payment limit program.

(5) "State licensing" means the entity assigned to regulate health care facilities.

R414-516-3. Quality Improvement Program Requirements of Participation.

(1) A program is required:

(a) to score better than the national average;

(b) improve from the prior state fiscal year (SFY); or

(c) not receive a state survey deficiency of F, H, I, J, K, or L in six of nine metrics.

(2) The metrics and state survey used for the QI Program are in accordance with the following data:

(a) CASPER percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine;

(b) CASPER percentage of long-stay residents with a urinary tract infection;

(c) CASPER percentage of high-risk long-stay residents with pressure ulcers;

(d) CASPER percentage of long-stay residents experiencing one or more falls with major injury;

(e) CASPER percentage of long-stay residents who lose too much weight;

(f) CASPER percentage of long-stay residents who receive an antipsychotic medication;

(g) CASPER percentage of long-stay residents whose ability to move independently worsens;

(h) adjusted nursing staff hours per resident per day; and
(i) a state survey without a quality of care deficiency of F, H, I, J, K, or L.
(3) If state licensing does not conduct a survey for a program in a given SFY, then the survey requirement described in (1)(i) of this section is removed from consideration, and the facility must meet five of eight metrics.
(4) If more than one survey is completed during the QI SFY, then all surveys are used for the period.
(5) The source of data used to calculate compliance comes from the CMS website, except for data described in Subsection R414-516-3(1)(i), which comes from state licensing. The data that represent the SFY are used for the analysis. Each program provides data to CMS for nursing hours and CASPER. The data is then made available in the subsequent SFY and will be downloaded by DMHF.
(6) DMHF does not require a provider that enters the NF NSGO UPL program for only part of an SFY, based on provider participation start date, to comply with the QI requirements described in Subsection (1) in the first SFY.

R414-516-4. Exceptions and Holdings.
(1) DMHF shall notify a program when it does not meet the requirements of Subsection R414-516-3(1), and place the program on probation during the subsequent SFY.
(2) The program must email to qiupl@utah.gov, a detailed description of why the facility did not comply with the requirements within 30 calendar days of receiving notice, and must send a corrective action plan detailing how the facility will comply in the subsequent SFY.
(3) If the program fails to comply with Subsection R414-516-3(1) for a second consecutive SFY, DMHF shall send the program a notice of failure to meet the requirements and shall remove the program from the seed contract.
(a) The program may submit within 30 days of receiving notice, a written request to remain in the seed contract, which contains evidence showing extraordinary circumstances that reasonably prevented the program from demonstrating compliance. Based on the evidence, DMHF may determine the program has provided sufficient documentation to meet its burden of proof and waive program removal from the seed contract.
(b) Effective the last day of the quarter in which DMHF determines non-compliance, DMHF shall remove the program from the seed contract, and the program may not receive payments for at least 12 months.
(c) If DMHF determines the program has complied with Subsection R414-516-3(1) for an entire subsequent SFY, DMHF shall amend the seed contract and reinstate the program effective the first day of the quarter after the determination is made.

KEY: Medicaid
Date of Last Change: June 19, 2020
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: New		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R414-523**	**Filing ID 54079**

Agency Information

1. Department:	Health	
Agency:	Health Care Financing, Coverage and Reimbursement Policy	
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 person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule or section catchline:
Extraordinary Care Definition for Spousal Caregiver Compensation
3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**
The purpose of this new rule, in accordance with S.B. 63 of the 2021 General Session, is to implement a definition for extraordinary care to use in the evaluation and authorization of caregiver compensation in applicable home and community-based services (HCBS) waiver programs.
4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**
This amendment implements a definition for extraordinary care to use in the evaluation and authorization of caregiver compensation in applicable HCBS programs. It also specifies limitations, spells out eligibility requirements, lists provisions for compensation, and specifies the Department's authority to deny a compensation request.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A) State budget:
There is an annual cost of $4,127,800 to implement caregiver compensation within applicable HCBS programs.
B) Local governments:
There is no impact on local governments because they neither fund nor provide HCBS services under the Medicaid program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no impact on small businesses as this rule only compensates caregivers in the home who provide extraordinary care for their spouses.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
There is no impact on non-small businesses as this rule only compensates caregivers in the home who provide extraordinary care for their spouses.
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***)**:**
About 360 spouses who meet the eligibility requirements to provide extraordinary care in the home may each receive about $11,466 in compensation based on the total amount of $4,127,800.
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 rule can only result in out-of-pocket savings for spouses who qualify to provide extraordinary care in the home.
G) Comments by the department head on the fiscal impact this rule may have on businesses (Include the name and title of the department head):
Businesses will see neither costs nor revenue as this rule only provides compensation for caregivers who provide extraordinary care in the home. Nate Checketts, Executive Director.
6. A) 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	**FY2022**	**FY2023**	**FY2024**
State Government	$4,127,800	$4,127,800	$4,127,800
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			
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$4,127,800	$4,127,800	$4,127,800
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

B) Department head approval of regulatory impact analysis:
The Executive Director of the Department of Health, Nate Checketts, has reviewed and approved this fiscal analysis.

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 26-1-5	Section 26-18-3	Section 26-18-424

Public Notice Information

9. 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 (mm/dd/yyyy)**:**	12/15/2021

10. This rule change MAY become effective on (mm/dd/yyyy)**:**	12/22/2021
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date. To make this rule effective, the agency must submit a Notice of Effective Date to the Office of Administrative Rules on or before the date designated in Box 10.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee, and title:	Nate Checketts, Executive Director	**Date** (mm/dd/yyyy)**:**	11/01/2021

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

R414-523. Extraordinary Care Definition for Spousal Caregiver Compensation.

R414-523-1. Introduction and Authority.

This rule implements a definition for extraordinary care to use in the evaluation and authorization of caregiver compensation in applicable home and community-based services waiver programs. This rule is authorized by Section 26-18-424.

R414-523-2. Definitions.

(1) "Care planning team" means the case manager or support coordinator selected or assigned to the participant and includes other individuals based on the participant's preference who help determine the support a participant receives.

(2) "HCBS waiver" means a home and community-based waiver program authorized under Section 1915(c) of the Social Security Act.

(3) "Participant" means a participant in the HCBS Waiver who is enrolled in the applicable program and for whom usage of caregiver compensation is evaluated.

R414-523-3. State Definition of Extraordinary Care.

Extraordinary care means care that exceeds the range of activities of daily living (ADLs) or instrumental activities of daily living (IADLs) that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the participant and avoid institutionalization. Extraordinary care may include specialized skills and tasks that the individual needs to perform for the waiver participant.

R414-523-4. Eligibility for Spousal Caregiver Compensation.

(1) A spouse may be eligible to perform direct care if:

(a) the spouse is the choice of the participant and supported by the care planning team;

(b) the spouse is not directing services on behalf of the participant;

(c) the spouse agrees to provide no more than what is approved, limited, and established in the participant's care or service plan; and

(d) the spouse can meet the needs of the participant. For example, the spouse has specialized training such as nursing licensure or is determined able by the Department to meet the participant's health and safety needs.

R414-523-5. Limitations.

(1) The availability of spousal caregiver compensation is restricted to HCBS waiver programs, and if part of the state's approved waiver implementation plan.

(2) This rule does not pertain to the evaluation and authorization of caregiver compensation for parents of minor children or guardians or when a guardian is not the spouse of a participant.

R414-523-6. Denial of Access to Spousal Caregiver Compensation.

(1) During initial and subsequent care planning meetings, the participant's case manager or support coordinator reviews the authorization for caregiver compensation to determine whether:

(a) the choice of the spouse to provide waiver services reflects the participant's wishes and desires;

(b) the provision of services is in the participant's and family's best interests;

(c) the provision of services is appropriate and based on the participant's identified needs; and

(d) the services will increase the participant's independence and community integration.

(2) The Department shall deny the request for spousal caregiver compensation if the caregiver does not meet any of the conditions in Subsection (1).

(3) The participant may appeal the Department's denial in accordance with the hearing rights described under Rule R410-14.

KEY: Medicaid
Date of Last Change: New Rule
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; 26-18-424