DMHF Rules Matrix 5-19-22

Rule Summary	Bulletin Publication	Effective
R414-100 Medicaid Primary Care Network Services (Five-Year Review); The Department will continue this rule because it defines and spells out services under the Primary Care Network.	**5-1-22**	**4-15-22**
R414-200 Non-Traditional Medicaid Health Plan Services (Five-Year Review); The Department will continue this rule because it defines and spells out services available to Non-Traditional Medicaid members.	**5-1-22**	**4-15-22**
R414-1 Utah Medicaid Program; The purpose of this change is to update and clarify the rule text as needed to coincide with the merger of the Department of Health and the Department of Human Services.	**5-15-22**	**7-1-22**
R382-1 Benefits and Administration; The purpose of this change is to update and clarify the rule text as needed. This amendment, therefore, updates and clarifies terms and entities in the text and makes other technical changes.	**5-15-22**	**7-1-22**
R382-2 Electronic Personal Medical Records for the Children's Health Insurance Program; The purpose of this change is to update and clarify the rule text as needed. This amendment, therefore, updates and clarifies terms and entities in the text and makes other technical changes.	**5-15-22**	**7-1-22**
R382-3 Accountable Care Organization Incentives to Appropriately Use Emergency Room Services in the Children's Health Insurance Program; The purpose of this change is to update and clarify the rule text as needed. This amendment, therefore, updates and clarifies terms and entities in the text and makes other technical changes.	**5-15-22**	**7-1-22**

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 November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-100**	**Filing ID: (Office Use Only)**
Effective Date:	**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 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
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:
Medicaid Primary Care Network 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 Medicaid policy through administrative rules while Section 26-1-5 authorizes the Department to adopt, amend, or rescind rules as necessary.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it defines and spells out services under the Primary Care Network.

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, Executive Director	**Date** (mm/dd/yyyy)**:**	04/15/2022
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.
R414-100. Medicaid Primary Care Network Services.
R414-100-1. Introduction and Authority.

This rule lists the services under the Medicaid Primary Care Network (PCN). The Primary Care Network is authorized by a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act effective January 1, 1999. This rule is authorized by Title 26, Chapter18, UCA.

R414-100-2. Definitions.

(1) "Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of

sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(a) placing the enrollee's health in serious jeopardy;

(b) serious impairment to bodily functions;

(c) serious dysfunction of any bodily organ or part; or

(d) death.

(2) "Emergency services" means:

(a) attention provided within 24 hours of the onset of symptoms or within 24 hours of diagnosis;

(b) for a condition that requires acute care, and is not chronic;

(c) reimbursed only until the condition is stabilized sufficient that the patient can leave the hospital emergency department; and

(d) is not related to an organ transplant procedure.

(2) "Outpatient" means an enrollee who receives services from a licensed outpatient care facility.

(3) "Primary care" means services to diagnose and treat illness and injury as well as preventive health care services. Primary care promotes early identification and treatment of health problems, which can help to reduce unnecessary complications of illness or injury and maintain or improve overall health status.

R414-100-3. Services Available.

(1) To meet the requirements of 42 CFR 431.107, the department contracts with each provider who furnishes services under the PCN.

(2) By signing a provider agreement with the department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

(3) By signing an application for Medicaid coverage, the enrollee agrees that the department's obligation to reimburse for services is governed by contract between the department and the provider.

(4) Medical or hospital services for which providers are reimbursed under the PCN are generally limited by federal guidelines as set forth under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

(5) The following services in the Medicaid Primary Care Network are available to those adults found eligible under Section 1931 of the federal Social Security Act (Aid to Families of Dependent Children adults and medically needy adults):

(a) emergency services only in a designated hospital emergency department;

(b) primary care physician services provided directly by licensed physicians or osteopaths, or by licensed certified nurse practitioners, or physician assistants under appropriate supervision of the physician or osteopath, but not including pregnancy related or mental health services by any of the listed providers;

(c) services associated with surgery or administration of anesthesia are physician services to be provided by physicians or licensed certified nurse anesthetists;

(d) laboratory and radiology services by licensed and certified providers;

(e) durable medical equipment, supplies and appliances used to assist the patient's medical recovery;

(f) preventive services, immunizations and health education methods and materials to promote wellness, disease prevention and manage illnesses;

(g) pharmacy services by a licensed pharmacy limited to four prescriptions per month, per client with no overrides or exceptions in the number of prescriptions;

(h) dental services are limited to examinations, cleanings, fillings, extractions, treatment of abscesses or infections and to be covered must be provided by a dentist in the office;

(i) transportation services limited to ambulance (ground and air) service for medical emergencies;

(j) interpretive services provided by contracting entities competent to provide medical translation services for people with limited English proficiency and interpretive services for the deaf; and

(k) vision services once every 12 months including an eye examination/refraction by a licensed ophthalmologists or optometrists, but not including the cost of glasses or other refractive device.

KEY: Medicaid, primary care network

Date of Enactment or Last Substantive Amendment: September 27, 2017
Notice of Continuation: May 5, 2017
Authorizing, and Implemented or Interpreted Law: 26-18

State of Utah
Administrative Rule Analysis
Revised November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-200**	**Filing ID: (Office Use Only)**
Effective Date:	**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 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
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:
Non-Traditional Medicaid Health Plan 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 Medicaid policy through administrative rules while Section 26-1-5 authorizes the Department to adopt, amend, or rescind rules as necessary. Additionally, Section 1115 of the Social Security Act authorizes these services under a waiver of federal Medicaid requirements.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it defines and spells out services available to Non-Traditional Medicaid members.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee, and title:	Nate Checketts, Executive Director	**Date** (mm/dd/yyyy)**:**	04/15/2022
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.
R414-200. Non-Traditional Medicaid Health Plan Services.
R414-200-1. Introduction and Authority.

This rule lists the services under the Non-Traditional Medicaid Health Plan (NTHP). This plan is authorized by a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act effective January 1, 1999. This rule is authorized by Title 26, Chapter 18, UCA.

R414-200-2. Definitions.

The definitions in Rule R414-1 apply to this rule.

R414-200-3. Services Available.

(1) To meet the requirements of 42 CFR 431.107, the Department contracts with each provider who furnishes services under the Non-Traditional Medicaid (NTM) Health Plan.

(a) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid information bulletins, and provider letters.

(b) By signing an application for Medicaid coverage, the applicant agrees that the Department's obligation to reimburse for services is governed by contract between the Department and the provider.

(2) Medical or hospital services for which providers are reimbursed under the NTM Health Plan are limited by federal guidelines as set forth under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

(3) The following services, as more fully described and limited in provider contracts, provider manuals, and administrative rules, are available to NTM Health Plan members:

(a) inpatient hospital services, provided by bed occupancy for 24 hours or more in an approved acute care general hospital under the care of a physician if the admission meets the established criteria for severity of illness and intensity of service;

(b) medically necessary outpatient hospital services that include diagnostic, therapeutic, preventive, or palliative care, which are provided for less than 24 hours in outpatient departments located in or physically connected to an acute care general hospital;

(c) emergency services in dedicated hospital emergency departments;

(d) physician services provided directly by licensed physicians or osteopaths, or by licensed certified nurse practitioners or licensed certified nurse midwives under appropriate supervision of a physician or osteopath;

(e) physician assistants may render services as independent practitioners pursuant to Title 58, Chapter 70a, Utah Physician Assistant Act;

(f) services associated with surgery or administration of anesthesia provided by physicians or licensed certified nurse anesthetists;

(g) vision care services by licensed ophthalmologists or licensed optometrists, within their scope of practice, limited to one annual eye examination or refraction and no eyeglasses;

(h) laboratory and radiology services provided by licensed and certified providers;

(i) dialysis to treat end-stage renal failure provided at a Medicare-certified dialysis facility;

(j) home health services defined as intermittent nursing care or skilled nursing care provided by a Medicare-certified home health agency;

(k) hospice services provided by a Medicare-certified hospice to terminally ill members with a six-month or less life expectancy, who elect to receive palliative care instead of aggressive care;

(l) abortion and sterilization services to the extent permitted by federal and state law and meeting the documentation requirement of 42 CFR 440, Subparts E and F;

(m) organ transplants, limited to kidney, liver, cornea, bone marrow, stem cell, heart, and lung transplants;

(n) services provided in freestanding emergency centers, surgical centers and birthing centers;

(o) transportation services, limited to ground and air ambulance for medical emergencies.

(p) preventive services, immunizations and health education activities and materials to promote wellness, prevent disease, and manage illness;

(q) family planning services provided by or authorized by a physician, certified nurse midwife, nurse practitioner, or a physician assistant to the extent permitted by federal and state law, but not to include infertility drugs, in-vitro fertilization, and genetic counseling;

(r) pharmacy services provided by a licensed pharmacy;

(s) inpatient mental health services;

(t) outpatient mental health services;

(u) outpatient substance abuse services;

(v) hearing evaluations or assessments for hearing aids. NTM, however, will only cover hearing aids for congenital hearing loss;

(w) dental services as allowed in the Utah Medicaid State Plan, ATTACHMENT 3.1-A, Attachment #10;

(x) interpretive services if they are provided by entities under contract with the Department of Health to provide medical translation services for people with limited English proficiency and interpretive services for the deaf;

(y) physical therapy services provided by a licensed physical therapist if authorized by a physician, limited to 16 aggregated physical or occupational therapy visits per calendar year; and

(z) occupational therapy services provided for fine motor development, limited to 16 aggregated physical or occupational therapy visits per year.

(4) NTM does not cover the following:

(a) chiropractic services;

(b) speech-language pathology services;

(c) long-term care;

(d) private duty nursing;

(e) non-emergency transportation; and

(f) bus passes.

KEY: Medicaid, non-traditional, cost sharing
Date of Last Change: November 15, 2021
Notice of Continuation: May 5, 2017
Authorizing, and Implemented or Interpreted Law: 26-18

State of Utah
Administrative Rule Analysis
Revised November 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R414-1**	**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:

Utah Medicaid Program

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 and clarify the rule text as needed to coincide with the merger of the Department of Health and the Department of Human Services.

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 updates and clarifies terms and entities within the text, and makes other technical changes.

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 there are only minor changes and technical updates.

B) Local governments:

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

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

There is no impact on small businesses as there are only minor changes and technical updates.

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

There is no impact on non-small businesses as there are only minor changes and technical updates.

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

There is no impact to other persons or entities as there are only minor changes and technical updates.

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

There are no compliance costs to a single person or entity as there are only minor changes and technical updates.

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 no fiscal impact with these minor changes and technical updates to coincide with the Department merger (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	**FY2023**	**FY2024**	**FY2025**
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	

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)**:**		06/14/2022
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)**:**	06/21/2022

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	**Date** (mm/dd/yyyy)**:**	04/29/2022

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-1. Utah Medicaid Program.
R414-1-2. Definitions.

The following definitions are used throughout the rules of the Division:

(1) "Act" means the federal Social Security Act.

(2) "Applicant" means any person who requests assistance under the medical programs available through the Division.

(3) "Categorically needy" means an aged, blind or disabled individual[~~s~~] or family[~~families~~] or[~~and~~] child[~~children~~]:

(a) who is[~~are~~] otherwise eligible for Medicaid; and

(i) who meets the financial eligibility requirements for Aid to Families with Dependent Children [~~AFDC~~]as in effect in the Utah Medicaid State Plan on July 16, 1996; or

(ii) who meets the financial eligibility requirements for Supplemental Security Income (SSI) or an optional State supplement, or is[~~are~~] considered under [~~s~~]Section 1619(b) of the federal Social Security Act to be an SSI recipient[~~s~~]; or

(iii) who is a pregnant woman whose household income does not exceed 133% of the federal poverty guideline; or

(iv) is under age six and whose household income does not exceed 133% of the federal poverty guideline; or

(v) who is a child under age one born to a woman who was receiving Medicaid on the date of the child's birth and the child remains with the mother; or

(vi) who is at least six years of age, [~~six~~]but not yet 18 years of age[~~18~~], or is at least six years of age[~~six~~], but not yet 19 years of age [~~19~~]and was born after September 30, 1983, and whose household income does not exceed 100% of the federal poverty guideline; or

(vii) who is aged or disabled and whose household income does not exceed 100% of the federal poverty guideline; or

(viii) who is a child for whom an adoption assistance agreement with the state is in effect.

(b) whose categorical eligibility is protected by statute.

(4) "Code of Federal Regulations" (CFR) means the publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid Program.

(5) "[~~Client~~]Member" means a person the Division or its [~~duly~~]constituted agent has determined to be eligible for assistance under the Medicaid program.

(6) "CMS" means The Centers for Medicare and Medicaid Services, a [~~F~~]federal agency within the United States (U.S.) Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, and the [~~State~~]Children's Health Insurance Program.

(7) "Department" means the Department of Health and Human Services (DHHS)[~~Department of Health~~].

(8) "Director" means the director of the Division.

(9) "Division" means the Division of Integrated Healthcare within the Department[~~Division of Health Care Financing within the Department~~].

(10) "Emergency medical condition" means a medical condition showing acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(a) placing the patient's health in serious jeopardy;

(b) serious impairment to bodily functions;

(c) serious dysfunction of any bodily organ or part; or

(d) death.

(11) "Emergency service" means immediate medical attention and service performed to treat an emergency medical condition. Immediate medical attention is treatment [~~rendered~~]given within 24 hours of the onset of symptoms or within 24 hours of diagnosis.

(12) "Emergency Services Only Program" means a health program designed to cover a specific range of emergency services.

(13) "Executive Director" means the executive director of the Department.

(14) "InterQual" means the McKesson Criteria for Inpatient Reviews, a comprehensive, clinically based, patient focused medical review criteria and system developed by McKesson Corporation.

(15) "Medicaid agency" means [~~the Department of Health~~]DHHS.

(16) "Medical assistance program" or "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act; as implemented by Title 26, Chapter 18, Medical Assistance Act.

(17) "Medical or hospital assistance" means the service[~~s~~] furnished or a payment[~~s~~] made to or on behalf of a recipient[~~s~~] under medical programs available through the Division.

(18) "Medically necessary service" means that:

(a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and

(b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

(19) "Medically needy" means an aged, blind, or disabled individual[~~s~~] or family[~~ies~~] or[~~and~~] child[~~ren~~] who is[~~are~~] otherwise eligible for Medicaid, who is[~~are~~] not categorically needy, and whose income and resources are within limits set under the Medicaid State Plan.

(20) "Medical standards," as applied in this rule, means that an individual may receive reasonable and necessary medical services up until the time a physician makes an official determination of death.

(21) "Prior authorization" means the required approval for provision of a service that the provider must obtain from the Department before providing the service. Details for obtaining prior authorization are found in Section I of the Utah Medicaid Provider Manual.

(22) "Provider" means any person, individual or corporation, institution or organization that provides medical, behavioral or dental care services under the Medicaid program and who has entered into a written contract with the Medicaid program.

(23) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program, or has had a premium paid to a managed care entity.

(24) "Undocumented alien" means an alien who is not recognized by Immigration and Naturalization Services as being lawfully present in the United States.

(25) "Utilization review" means the Department provides for review and evaluation of the utilization of inpatient Medicaid services provided in acute care general hospitals to patients entitled to benefits under the Medicaid plan.

(26) "Utilization Control" means the Department [~~has~~]implements[~~ed~~] a statewide program of surveillance and utilization control that safeguards against unnecessary or inappropriate use of Medicaid services, safeguards against excess payments, and assesses the quality of services available under the plan. The program meets the requirements of 42 CFR, Part 456.

R414-1-3. Single State Agency.

[~~The Utah Department of Health~~]DHHS is the [~~S~~]single [~~S~~]state [~~A~~]agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the federal Social Security Act.

R414-1-4. Medical Assistance Unit.

Within the [~~Utah Department of Health~~]DHHS, the Division of Integrated Healthcare[~~Division of Health Care Financing~~] has been designated as the medical assistance unit.

R414-1-11. Administrative Hearings.

The Department has a system of administrative hearings for any medical provider,[~~s and~~] dissatisfied applicant,[~~s, clients, and recipients~~] or member that meets all the requirements of 42 CFR[~~,~~] Part 431, Subpart E.

R414-1-13. Provider and [~~Client~~]Member Agreements.

(1) To meet the requirements of 42 CFR 431.107, the Department contracts with each provider who furnishes services under the Utah Medicaid Program.

(2) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

(3) By signing an application for Medicaid coverage, the [~~client~~]member agrees that the Department's obligation to reimburse for services is governed by contract between the Department and the provider.

R414-1-16. Confidentiality.

[~~State statute, ~~]Title 63G, Chapter 2, Government Records Access and Management Act and Section 26-1-17.5[~~,~~] impose legal sanctions and provide safeguards that restrict the use or disclosure of information concerning an applicant[~~s~~], a [~~clients~~]member, and a recipient[~~s~~] to purposes directly connected with the administration of the plan.

All other requirements of 42 CFR Part 431, Subpart F are met.

R414-1-17. Eligibility Determinations.

The determination[~~Determinations of eligibility for~~] of Medicaid eligibility [~~under the plan are~~]is made by the Department and[~~Division of Health Care Financing,~~] the [~~Utah~~]Department of Workforce Services[~~, and the Utah Department of Human Services~~]. There is a written agreement [~~among~~]between the [~~Utah~~]Department [~~of Health,~~]and the [~~Utah~~]Department of Workforce Services[~~, and the Utah Department of Human Services~~]. The agreement defines the relationships and respective responsibilities of the agencies.

R414-1-19. Timeliness in Eligibility Determinations.

The Medicaid agency shall adhere to [~~all~~]the timeliness requirements [~~of~~]found in 42 CFR 435.911, for processing applications, determining eligibility, and approving Medicaid requests. If these requirements are not completed within the defined time limits, [~~clients~~]members may notify the Division.[~~Division of Health Care Financing at 288 North, 1460 West, Salt Lake City, UT 84114-2906~~].

R414-1-26. General Rule Format.

The following format is used generally throughout the rules of the Division. Section headings as indicated and the following general definitions are for guidance only. The section headings are not part of the rule content itself. In certain instances, this format may not be appropriate and will not be implemented due to the nature of the subject matter of a specific rule.

(1) [~~Introduction and Authority. ~~]A concise statement as to what Medicaid service is covered by the rule, and a listing of specific federal statutes and regulations and state statutes that authorize or require the rule.

(2) [~~Definitions. ~~]Definitions that have special meaning to the particular rule.

(3) [~~Client Eligibility. ~~]Categories of Medicaid [~~clients~~]members eligible for the service covered by the rule that include [~~: C~~]categorically [~~N~~]needy members,[~~or M~~]medically [~~N~~]needy members, or both. Conditions precedent to the [~~client's~~]member's obtaining coverage such as age limitations or otherwise.

(4) Program [~~A~~]access [~~R~~]requirements[~~.~~] that include [~~C~~]conditions [~~precedent ~~]external to the [~~client's~~]member obtaining service, such as type of certification needed from attending physician, whether available only in an inpatient setting or otherwise.

(5) Service [~~C~~]coverage[~~.~~] that [~~D~~]details [~~of ~~]specific services available under the rule, including limitations, such as number of procedures in a given period [~~of time~~]or otherwise.

(6) [~~Prior Authorization. ~~]As necessary, a description of the procedures for obtaining prior authorization for services available under the particular rule. [~~However, p~~]Prior authorization, however, [~~must~~]may not be used as a substitute for regulatory practice that should be in rule.

(7) [~~Other Sections. ~~]As necessary under the particular rule, additional sections may be indicated. Other sections include regulatory language that does not fit into Subsections (1) through (5).

R414-1-27. Determination of Death.

(1) In accordance with [~~the provisions of~~]Section 26-34-2, the fiduciary responsibility for medically necessary care on behalf of the [~~client~~]member ceases upon the determination of death.

(2) Reimbursement for the determination of death by acceptable medical standards must be in accordance with Medicaid coverage and billing policies [~~that are~~]in place on the date the physician renders services.

KEY: Medicaid
Date of Last Change: November 15, 2021
Notice of Continuation: December 13, 2021
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; 26-34-2

State of Utah
Administrative Rule Analysis
Revised November 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R382-1**	**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 and Administration
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 and clarify the rule text as needed.
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 updates and clarifies terms and entities in the text. It also makes other technical changes.

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 there are only minor changes and technical updates.
B) Local governments:
There is no impact on local governments as they neither fund nor provide benefits under the Children's Health Insurance Program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no impact on small businesses as there are only minor changes and technical updates.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
There is no impact on non-small businesses as there are only minor changes and technical updates.
E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**
There is no impact to other persons or entities as there are only minor changes and technical updates.
F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**
There are no compliance costs to a single person or entity as there are only minor changes and technical updates.
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 no fiscal impact with these minor changes and technical updates (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	**FY2023**	**FY2024**	**FY2025**
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 26-40-103	

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)**:**		06/14/2022
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)**:**	06/21/2022

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	**Date** (mm/dd/yyyy)**:**	04/29/2022

R382. Health, Children's Health Insurance Program.
R382-1. Benefits and Administration.
R382-1-1. Authority and Purpose.

This rule implements the Children's Health Insurance Program under Title XXI of the Social Security Act, as adopted in the state under Title 26, Chapter 40, Utah Children's Health Insurance Act. It is authorized by Section 26-40-103.

R382-1-2. Definitions.

The definitions found in Title 26, Chapter 40, Utah Children's Health Insurance Act apply to this rule. [~~In addition,~~]The following definitions also apply.

(1) "Applicant" means a child under [~~the age of~~]19 years of age on whose behalf an application has been made for benefits under the Children's Health Insurance Program (CHIP), but who is not an enrollee.

(2) "CHIP" means the Children's Health Insurance Program.

(3) "CHIP Beneficiary" means a child under 19 years of age who is determined eligible for the Children's Health Insurance Program.

([~~2~~]4) "Department" means the Utah Department of Health and Human Services.

[~~(3) "Enrollee" means a child under the age of 19 who has applied for and has been found eligible for benefits under CHIP.~~]

R382-1-3. Nature of Program and Benefits.

(1) CHIP provides reimbursement to medical providers for the services they [~~render~~]give to a child who meets the eligibility and application requirements of Rule R382-10. CHIP provides limited benefits as described in this rule. The Department provides reimbursement coverage under the program only for benefits and levels of coverage for each program benefit:

(a) as provided in rule governing CHIP; and

(b) as described and limited in Section 6.2 of the State Plan for the Children's Health Insurance Program, April 17. 2009 ed., which is adopted and incorporated by reference.

(2) CHIP is not health insurance. A relationship with the Department as the insurer and the [~~enrollee~~]beneficiary as the insured does not exist under this program.

R382-1-4. Limitation of Abortion Benefits.

The Department may only cover abortion in accordance with [~~the provisions of~~]42 U.S.C. Sec. 1397ee.

R382-1-5. Providers.

The Department requires a child to enroll in one of the managed care organizations (MCO) that contracts with the Department under the program.

R382-1-6. Reimbursement.

(1) The Department shall reimburse only for benefits as limited in its contracts with the MCOs.

(2) Payment for services by the contracted MCO and [~~enrollee~~]the CHIP beneficiary co-payment, if any, constitutes full payment for services. A provider may not bill or collect any additional monies for services rendered.

R382-1-7. Cost Sharing.

A provider may require [~~an enrollee~~]a CHIP beneficiary to pay a co-payment equal to that listed in Section 8 of the State Plan for the Children's Health Insurance Program, April 17, 2009 ed., which is adopted and incorporated by reference.

R382-1-8. Agency Conferences, Fair Hearings, and Appeals.

(1) [~~An~~]A CHIP applicant or [~~enrollee~~]beneficiary may request an agency conference in accordance with Section R414-301-5 at any time to resolve a problem without requesting an agency action under the Utah Administrative Procedures Act (UAPA).

(2) The CHIP applicant or [~~enrollee~~]beneficiary, parent, legal guardian, or authorized representative may request an agency action, also called a fair hearing, if [~~he~~]the individual disagrees with an agency decision regarding the individual's eligibility. The request for a fair hearing must be in accordance with [~~the provisions and time limits of~~]Section R414-301-[~~6~~]7.

(3) The Department of Workforce Services [~~(DWS)~~]shall conduct fair hearings on eligibility in accordance with [~~the provisions of~~]Section R414-301-[~~6~~]7.

(4) If [~~an enrollee~~]a CHIP beneficiary disagrees with a decision of the MCO regarding a covered benefit or service, [~~the enrollee~~]the beneficiary may appeal the decision through the MCO.

(a) [~~An enrollee~~]A CHIP beneficiary must exhaust grievance remedies with the MCO before [~~he~~]the beneficiary requests an agency action from the Department.

(b) The [~~enrollee~~]CHIP beneficiary may file an appeal with the Department if the [~~enrollee~~]beneficiary disagrees with the MCO's resolution. The [~~enrollee~~]beneficiary must file the appeal within 60 days of the date that the MCO sends the resolution notice.

(c) The Department shall conduct a review of the MCO's decision in accordance with [~~the provisions of~~]42 CFR 438.408 and issue a final decision to the [~~enrollee~~]CHIP beneficiary and the MCO.

(d) The Department shall conduct all appeals in accordance with UAPA.

(e) The [~~enrollee~~]CHIP beneficiary may continue to receive benefits if the [~~enrollee~~]beneficiary meets the conditions of 42 CFR 438.420.

KEY: children's health benefits, fair hearings
Date of Last Change: June 16, 2011
Notice of Continuation: April 11, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40-103

State of Utah
Administrative Rule Analysis
Revised November 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R382-2**	**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:

Electronic Personal Medical Records for the Children's Health Insurance Program

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 and clarify the rule text as needed.

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 updates and clarifies terms and entities in the text. It also makes other technical changes.

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 there are only minor changes and technical updates.

B) Local governments:

There is no impact on local governments as they neither fund nor provide benefits under the Children's Health Insurance Program.

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

There is no impact on small businesses as there are only minor changes and technical updates.

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

There is no impact on non-small businesses as there are only minor changes and technical updates.

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

There is no impact to other persons or entities as there are only minor changes and technical updates.

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

There are no compliance costs to a single person or entity as there are only minor changes and technical updates.

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 no fiscal impact with these minor changes and technical updates (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	**FY2023**	**FY2024**	**FY2025**
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 26-40-103	

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*)**:**

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Official Title of Materials Incorporated (from title page)	
Publisher	
Date Issued	
Issue, or version	

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	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)**:**		06/14/2022
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)**:**	06/21/2022
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	**Date** (mm/dd/yyyy)**:**	04/29/2022

R382. Health, Children's Health Insurance Program.

R382-2. Electronic Personal Medical Records for the Children's Health Insurance Program.

R382-2-1. Introduction and Authority.

This rule is promulgated under authority granted in Section 26-40-103, as last amended by Laws of Utah 2012, Chapters 28 and 369.

R382-2-2. Purpose.

This rule establishes requirements for enrolling Children's Health Insurance Program (CHIP) beneficiaries in the electronic exchange of clinical health information unless the beneficiary or the beneficiary's parent or legal guardian opts the beneficiary out.

R382-2-3. Definitions.

These definitions apply to Rule R382-2:

(1) "Technical [~~S~~]specifications" means the technical specifications document published by the Utah Health Information Network (UHIN) that describes the variables and formats of the data to be submitted as well as submission directions and guidelines.

(2) "Program website" means the website for the Department of Health and Human Services Division of Integrated Healthcare, and the website for CHIP.

[~~"Program Website" means the Department of Health, Department of Workforce Services, Division of Medicaid and Health Financing, and the CHIP websites.~~]

R382-2-4. Enrollment Notification.

(1) [~~Prior to~~]Before the enrollment process in the Clinical Health Information Exchange ([~~e~~]CHIE), the Department [~~will~~]provides [~~N~~]notice of [~~I~~]intent to enroll a CHIP

beneficiary[~~beneficiaries~~] in [~~e~~]CHIE and includes the right of a beneficiary[~~beneficiaries~~] to opt out.

(2) The Department [~~will~~]provides additional education regarding the beneficiary's right to opt out on the program websites.

R382-2-5. Enrollment Process.

(1) The Department [~~will~~]provides [~~e~~]CHIE an enrollment file of [~~all~~] CHIP beneficiaries.

(2) The enrollment file [~~will~~]contains the succeeding month's CHIP enrollment.

(3) [~~e~~]CHIE [~~will~~]enrolls a CHIP beneficiary[~~beneficiaries~~] on the first day of the succeeding month.

(4) [~~Submission procedures and guidelines, including required data elements, will be described in detail in the technical specifications published by UHIN and will be included in the Department's Operating Agreement with cHIE.~~]Technical specifications published by UHIN and the Department's operating agreement with CHIE describe detailed submission procedures and guidelines, including required data elements.

(5) The Department [~~will~~]uses a secure format to transfer any enrollment files to [~~e~~]CHIE.

R382-2-6. Exemptions.

(1) An individual's previous consent status in [~~e~~]CHIE [~~will be~~]is honored by [~~e~~]CHIE and [~~will~~]is not [~~be~~]overridden by the CHIP enrollment file.

KEY: CHIP, [e]CHIE
Date of Enactment or Last Substantive Amendment: September 1, 2012
Notice of Continuation: July 31, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40-103

State of Utah
Administrative Rule Analysis
Revised November 2021

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
	Title No. - Rule No. - Section No.	
Utah Admin. Code Ref (R no.):	**R382-3**	**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:

Accountable Care Organization Incentives to Appropriately Use Emergency Room Services in the Children's Health Insurance Program

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 and clarify the rule text as needed.

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 updates and clarifies terms within the text. It also makes other technical changes.

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 there are only minor changes and technical updates.

B) Local governments:

There is no impact on local governments as they neither fund nor provide benefits under the Children's Health Insurance Program.

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

There is no impact on small businesses as there are only minor changes and technical updates.

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

There is no impact on non-small businesses as there are only minor changes and technical updates.

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***)**:**

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

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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 no fiscal impact with these minor changes and technical updates (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	**FY2023**	**FY2024**	**FY2025**
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 26-40-103	

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*)**:**

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Official Title of Materials Incorporated (from title page)	
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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*)**:**

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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)**:**	06/14/2022

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)**:**	06/21/2022
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	**Date** (mm/dd/yyyy)**:**	04/29/2022

R382. Health, Children's Health Insurance Program.

R382-3. [~~Accountable~~]Managed Care Organization Incentives to Appropriately Use Emergency Room Services in the Children's Health Insurance Program.

R382-3-1. Introduction and Authority.

(1) This rule is established under the authority of Section 26-40-103.

(2) [~~The purpose of t~~]This rule [~~is to~~]establishes provisions governing [~~Accountable Care Organization (ACO)~~]managed care organization (MCO) performance measures for the reduction of non-emergent use of emergency departments by beneficiaries in the Children's Health Insurance Program (CHIP).

R382-3-2. Definitions.

(1) "CHIP Beneficiary" means a child under [~~the age of~~]19 years of age who is determined eligible for the Children's Health Insurance Program under Title XXI of the Social Security Act as adopted in the state under Title 26, Chapter 40.

(2) "Non-emergent medical condition" means a medical condition that does not meet the criteria of an emergency medical condition under 42 U.S.C. 1395dd (e) of the Emergency Medical Treatment and Active Labor Act.

(3) "Non-emergent medical care" means[~~:~~] medical care provided in an emergency room for the treatment of a non-emergent medical condition.

[~~(a) Medical care provided in an emergency room for the treatment of a non-emergent medical condition.~~]

(4) "Non-emergent medical care" does not mean:

(a) [~~M~~]medical services necessary to conduct a medical screening examination to determine if the CHIP beneficiary has an emergent or non-emergent medical condition; [~~and~~]nor

(b) [~~M~~]medical care provided to a CHIP beneficiary who[~~, using a prudent layperson standard, reasonably believes he~~] is experiencing an "emergency medical condition" as defined by 42 U.S.C. 1395dd(e) of the Emergency Medical Treatment and Active Labor Act.

R382-3-3. Performance Measures.

(1) An [~~ACO~~]MCO that contracts with the Department to provide services to CHIP beneficiaries shall report the following information to the Department in accordance with the terms of its contract:

(a) [~~E~~]emergency room visits with low acuity CPT codes 99281or 99282;

(b) [~~A~~]actions the [~~ACO~~]MCO takes to expand primary care and urgent care for CHIP beneficiaries who are enrolled in the [~~Accountable~~]managed [~~C~~]care [~~P~~]plan;

(c) [~~A~~]actions the [~~ACO~~]MCO takes to implement emergency room diversion plans that include[~~:~~

~~(i) W~~] weekday, evening, and weekend access to primary care providers and community health centers for CHIP beneficiaries; [~~and~~]

~~(ii) O~~]other innovations for expanding access to primary care[~~.~~]; and

(d) [~~O~~]other quality of care for CHIP beneficiaries who are enrolled in an [~~ACO~~]MCO as required by the Department.

KEY: children's health benefits
Date of Enactment or Last Substantive Amendment: January 13, 2014
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