DMHF Rules Matrix 12-15-22

Rule Summary	Bulletin Publication	Effective
R414-517 Inpatient Hospital Provider Assessments (Five-Year Review); The Department will continue this rule because it implements the Inpatient Hospital Assessment Act with its provisions for hospital audits, changes in hospital status, intergovernmental transfers, and penalties and interest.	**11-15-22**	**10-31-22**
R414-520 Admission Criteria for Medically Complex Children's Waiver; The purpose of this change is to provide waiver services for children with complex medical needs in accordance with H.B. 200, 2022 General Session. This amendment, therefore, includes level-of-care requirements to prioritize waiver participation, as increased funding allows for more children to receive waiver services. Criteria is based on scores derived from dependence on medical devices, treatments, therapies, subspecialty services, and impact on parents or guardians. This amendment also includes technical changes.	**11-15-22**	**12-22-22**
R414-22 Administrative Sanction Procedures and Regulations (Five-Year Review); The Department will continue this rule because it provides the Department and the Provider Sanction Committee discretionary authority to sanction providers for current and past misconduct, thereby promoting quality and integrity within the Medicaid program.	**12-1-22**	**11-7-22**
R414-515 Long Term Acute Care (Five-Year Review); The Department will continue this rule because it establishes long term acute care for Medicaid members that include provisions for member eligibility, program access, service coverage, preadmission review, continued stay review, and reimbursement.	**12-15-22**	**11-30-22**

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 June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-517**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

General Information

2. Rule catchline:
Inpatient Hospital Provider Assessments
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, and Title 26, Chapter 36b governs provisions for inpatient hospital assessments.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it implements the Inpatient Hospital Assessment Act with its provisions for hospital audits, changes in hospital status, intergovernmental transfers, and penalties and interest.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	10/30/2022
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-517. Inpatient Hospital Provider Assessments.
R414-517-1. Introduction and Authority.

This rule defines the scope of hospital provider assessment. This rule is authorized under Title 26, Chapter 36b, Inpatient Hospital Assessment Act.

R414-517-2. Definitions.

The definitions in Section 26-36b-103 apply to this rule.

R414-517-3. Audit of Hospitals.

(1) For a hospital that does not file a Medicare cost report for the time frames outlined in Section 26-36b-205, the Division of Medicaid and Health Financing (DMHF) shall audit the hospital's records to determine the correct discharges for the assessment.

(2) A hospital subject to the assessment shall make its records available for reasonable inspection upon written request from DMHF. DMHF shall consider a hospital that fails to make its records available to be non-compliant, and subject to the penalties set forth in Section R414-517-6.

R414-517-4. Change in Hospital Status.

(1)(a) If a hospital's status changes during any given year and it no longer falls under the definition of a hospital that is subject to the assessment outlined in Section 26-36b-205, the hospital must submit in writing to the Division of Medicaid and Health Financing (DMHF) a notice of the status change and the effective date of that change. The notice must be mailed to the correct address, as follows, and is only effective upon receipt by the Reimbursement Unit:

Via United States Postal Service:
Utah Department of Health
DMHF, BCRP
Attn: Reimbursement Unit
P.O. Box 143102
Salt Lake City, UT 84114-3102
Via United Parcel Service, Federal Express, and similar:
Utah Department of Health
DMHF, BCRP
Attn: Reimbursement Unit
288 North 1460 West
Salt Lake City, UT 84116-3231

(b) DMHF may identify a hospital that has changed status and will not include that hospital in the subsequent quarterly assessment.

(2) The following provisions apply for any period in which a hospital is no longer subject to the assessment and notice has been given under Subsection R414-517-4(1)(a), or when the hospital is identified by DMHF under Subsection R414-517-4(1)(b):

(a) DMHF shall require payment of the assessment from that hospital for the full quarter in which the status change occurred and the hospital will receive full payment, as outlined in Section 26-36b-210, for the applicable quarter; and

(b) the hospital is exempt from future assessment and not eligible for payment under this rule.

(3) For state fiscal year 2020 and subsequent years, before the beginning of each state fiscal year, DMHF shall determine whether a new provider is subject to the assessment. DMHF will add a newly identified provider prospectively, beginning that new state fiscal year. For example, a May 2019 evaluation that identifies a new provider will result in that new provider being added July 2019.

R414-517-5. Intergovernmental Transfer Calculation and Schedule.

DMHF shall calculate at a uniform rate for each hospital discharge, the non-state government hospital-intergovernmental transfer, as specified in Title 26, Chapter 36b, Inpatient Hospital Assessment Act. DMHF shall determine the uniform rate by using the total number of hospital discharges for non-state government hospitals, and shall apply uniformly any quarterly changes to the uniform rate to all non-state government hospitals.

R414-517-6. Penalties and Interest.

(1) If DMHF audits a hospital's records to determine the correct discharges for the assessment for a hospital required to file a Medicare cost report, but the hospital fails to provide its Medicare cost report within the timeline required, DMHF shall fine the hospital 5% of its annual calculated assessment. The fine is payable within 30 days of invoice.

(2) If DMHF audits a hospital's records to determine the correct discharges for the assessment because the hospital does not file a Medicare cost report and did not submit its discharges and supporting documentation within the timeline required, DMHF shall fine the hospital 5% of its annual calculated assessment. The fine is payable within 30 days of invoice.

(3) If a hospital fails to fully pay its assessment on or before the due date, DMHF shall fine the hospital 5% of its quarterly calculated assessment. The fine is payable within 30 days of invoice.

(4) On the last day of each quarter, if a hospital has any unpaid assessment or penalty, DMHF shall fine the hospital 5% of the unpaid amount. The fine is payable within 30 days of invoice.

(5)(a) If a hospital fails to pay its assessment on or before the due date, DMHF shall suspend payments to the hospital until the assessment and any fines or penalties are paid in full.

(b) DMHF shall provide written notice before withholding payments.

(c) When DMHF rescinds withholding of payments to a provider, it will, without notice, resume payments according to the regular claims payment cycle.

R414-517-7. Rule Repeal.

The Department shall repeal this rule in conjunction with the repeal of the Inpatient Hospital Assessment Act outlined in Section 26-36b-211.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: July 1, 2020
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; 26-36b

State of Utah
Administrative Rule Analysis
Revised June 2022

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-520**	**Filing ID: Office Use Only**

Agency Information

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

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

General Information

2. Rule or section catchline:

Admission Criteria for Medically Complex Children's Waiver

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 provide waiver services for children with complex medical needs in accordance with H.B. 200, 2022 General Session.

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 includes level-of-care requirements to prioritize waiver participation, as increased funding allows for more children to receive waiver services. Criteria is based on scores derived from dependence on medical devices, treatments, therapies, subspecialty services, and impact on parents or guardians. This amendment also includes technical changes.

Fiscal Information

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

A) State budget:

The Department expects an increase of about $1,000,000 to the state budget to provide waiver services to additional children who qualify for the Medically Complex Children's Waiver. This amount is based on gross expenditures of $3,505,600 versus gross revenues of $2,505,600 to provide these services.

B) Local governments:

Local education agencies will see an initial cost due to this legislation. This cost, however, will be offset by funding to provide Medicaid-eligible services in school settings to children with complex medical needs. After costs, these agencies will see net funding of about $350,000. This amount is based on $180,000 in total costs offset by $530,000 in total funding.

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

There is no impact on small businesses as this change will not result in additional costs, fees, taxes, or revenue.

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 change will not result in additional costs, fees, taxes, or revenue.

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***)**:**

Up to 130 children who qualify for the waiver, with their families, may see a share of about $1,000,000 in out-of-pocket savings. Additionally, service providers may see an increase in revenue, but there is no data to estimate an amount.

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 this change will not result in additional costs, fees, taxes, or revenue.

Regulatory Impact Table

Fiscal Cost	**FY2023**	**FY2024**	**FY2025**
State Government	$1,000,000	$1,000,000	$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	**$1,000,000**	**$1,000,000**	**$0**
Fiscal Benefits	**FY2023**	**FY2023**	**FY2025**
State Government	$0	$0	$0
Local Governments	$350,000	$350,000	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$1,000,000	$1,000,000	$0
Total Fiscal Benefits	**$1,350,000**	**$1,350,000**	**$0**
Net Fiscal Benefits	**$350,000**	**$350,000**	**$0**

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

The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this fiscal analysis. Businesses will not see additional costs, fees, taxes, or revenue.

Citation Information

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

Section 26B-1-213	Section 26-18-3	Section 26-18-410

Incorporations by Reference Information

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

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

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

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

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

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

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

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		12/15/2022
B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

9. This rule change MAY become effective on:	12/22/2022
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 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:	Tracy S. Gruber, Executive Director	**Date:**	10/31/2022

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-520. Admission Criteria for Medically Complex Children's Waiver.
R414-520-1. Introduction and Authority.

(1) This rule outlines the criteria used to evaluate initial and ongoing eligibility for the Medically Complex Children's Waiver.

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

R414-520-2. Definitions.

[~~(1)~~]"Waiver" means the Medically Complex Children's Waiver.

R414-520-3. Eligibility Requirements.

(1) The Department uses the following criteria to determine waiver eligibility:

(a) [~~A~~]an assessment of a child's ability to perform age-appropriate activities of daily living and that child's level of independence in the performance of the activity; and

(b) [~~A~~]an evaluation to determine whether a child meets nursing facility level-of-care in accordance with Section R414-502-3.

(2) For a child who meets the criteria in Subsection [~~R414-520-3~~](1), a point value is attributed to the initial application and annual re-evaluation that includes the following:

(a) [~~C~~]current medical providers;

(b) [~~C~~]condition or diagnosis;

(c) [~~D~~]date of last medical visit;

(d) [~~D~~]documentation of more than three months of dependence on medical devices, treatments, therapies, or subspecialty services to reach a minimum medical score; and

(e) [~~A~~]an evaluation of the impact on the parent[~~s~~] or guardian[~~s~~] who ha[~~ve~~]s provided care to the [~~medically complex~~]child with complex medical needs during the last 12 months.

R414-520-4. Waiver Access.

(1) The Department periodically assesses funding for the waiver to determine the number of children it[~~who~~] may [~~be~~]serve[~~d~~]. [~~It~~]The Department also derives a point value associated with the criteria found in Subsections R414-520-3(2)(d) through (e) to determine which children to enroll. In the event of multiple applications with the same point value, the Department [~~will~~]uses the point value derived from Subsection R414-520-3(2)(d) to make its determination.[~~In the event of multiple applications with the same point value derived from Subsection R414-520-3(2)(d), the Department will create a randomized list to determine which children are served.~~]

(2) The Department enrolls applicants who meet the level-of-care requirements using the scoring process described in Subsection (1) until the waiver reaches the maximum number of children it may serve. Once the waiver reaches the maximum number of children it may serve, the Department uses a waitlist to monitor interest in the program and to enroll additional children when attrition creates vacancies. The Department attributes a score to children who are enrolled and on the waitlist in accordance with Subsections R414-520-3(2)(d) through (e), and enrolls children based on the highest scores. In the event of multiple enrollees or

applicants with the same point value derived from Subsection R414-520-3(2)(d), the Department enrolls children based on the order in which it receives applications until the maximum number of children the waiver may serve is reached.

(3) Each calendar quarter, the Department reviews level-of-care annual re-certifications of current enrollees that were completed in the preceding quarter to determine a new minimum qualifying score for entrance or continued enrollment in the waiver. Participants who no longer meet the minimum qualifying score are disenrolled from the waiver.

([~~2~~]4) An applicant who is not admitted to the waiver, or a child who is disenrolled from the waiver, may appeal the decision in accordance with 42 CFR 431[~~,~~] Subpart E.

R414-520-5. Service Coverage.

Services and limitations are found in the State Implementation Plan for the Medically Complex Children's Waiver.

KEY: Medicaid
Date of Last Change: January 4, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26-18-3; 26-18-410

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-22**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

General Information

2. Rule catchline:
Administrative Sanction Procedures and Regulations
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Subsection 26-18-3(6) requires the Department to provide disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the Medicaid program. Further, 42 CFR 455 requires the Department to investigate fraud, and if necessary, to impose sanctions against providers.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it provides the Department and the Provider Sanction Committee discretionary authority to sanction providers for current and past misconduct, thereby promoting quality and integrity within the Medicaid program.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	11/05/2022
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-22. Administrative Sanction Procedures and Regulations.
R414-22-1. Introduction and Authority.

(1) In order to maintain the integrity of the Medicaid program, and to assure the safety of Medicaid members, the Department may implement administrative sanctions against providers who abuse or improperly apply the benefit program or otherwise conduct themselves contrary to law.

(2) This rule is authorized by Sections 26-1-5 and Subsection 26-18-3(7).

R414-22-2. Definitions.

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

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in reimbursement for services that are either not medically necessary or that fail to meet professionally recognized standards for health care.

(2) "Conviction" or "Convicted" means a criminal conviction entered by a federal or state court for fraud involving Medicare or Medicaid regardless of whether an appeal from that judgment is pending.

(3) "Fiscal agent" means an organization that processes and pays provider claims on behalf of the Department.

(4) "Fraud" means intentional deception or misrepresentation made by a person that results in some unauthorized Medicaid benefit to himself or some other person. It includes any act that constitutes fraud under applicable state law.

(5) "Member" means an individual who is determined eligible for Medicaid.

(6) "Offense" means any of the grounds for sanctioning set forth in Section R414-22-4.

(7) "Person" means any natural person, company, firm, association, corporation or other legal entity.

(8) "Practitioner" means a physician or other individual licensed under state law to practice his profession.

(9) "Provider" means an individual or other entity who has been approved by the Department to provide services to Medicaid members, and who has signed a provider agreement with the Department.

(10) "Provider Sanction Committee" means the committee within the Department of Health that determines whether a Medicaid provider with a conviction or other sanction identified in Subsection R414-22-3 (3), (4), or (5) may enroll or remain in the Medicaid program. This committee consists of a designee of the Executive Director of the Department of Health, a designee of the Office of Inspector General of Medicaid Services, and the bureau director over provider enrollment.

(11) "Suspension" means that Medicaid items or services provided by a provider under suspension shall not be reimbursed by the Department.

(12) "Termination from participation" means termination of the existing provider agreement.

R414-22-3. Grounds for Excluding Providers.

(1) Upon learning of the crime, misdemeanor or misconduct, the Department shall exclude a prospective Medicaid provider who:

(a) has a current suspension from the Division of Professional and Occupational Licensing (DOPL) or another state's equivalent agency for sexual misconduct with a child, minor, or non-consenting adult under Title 76 of the Criminal Code; or

(b) is serving any term, completing any associated probation or parole, or still making complete court imposed restitution for a felony conviction involving:

(i) a sexual crime;

(ii) a controlled substance; or

(iii) health care fraud; or

(c) is serving any term, completing any associated probation or parole, or still making complete court imposed restitution for a misdemeanor conviction that involves a controlled substance.

(2) Upon learning of the crime, misdemeanor or misconduct, the Department shall terminate a current Medicaid provider for any violation stated in Subsection R414-22-3(1).

(3) If a prospective or current Medicaid provider has a current restriction or probation on their license from DOPL or another state's equivalent agency to treat only a certain age group or gender, or DOPL requires another medical professional to supervise and restrict the provider's activity, then the Department will require the provider to submit the same documentation to the Department that the provider is required to submit to DOPL or another state's equivalent agency to demonstrate compliance with the restriction. Failure to submit such documentation to the Department is a basis for suspension or termination of enrollment with Medicaid.

(4) Subject to approval of the Provider Sanction Committee, the Department may enroll a provider who has served any term, completed any associated probation or parole, or made complete court-imposed restitution for a prior felony conviction involving:

(a) a sexual crime;

(b) a controlled substance; or

(c) health care fraud.

(5) Subject to approval of the Provider Sanction Committee, the Department may enroll a provider or allow a provider to remain in the Medicaid program if the provider has a previous restriction, suspension, or probation from DOPL for sexual misconduct with a child, minor, or non-consenting adult under Title 76 of the Criminal Code.

(6) Subject to approval of the Provider Sanction Committee, the Department may allow a provider to remain in the Medicaid program when the Office of Inspector General of Medicaid Services has recommended the program consider termination of the provider.

(7) The Provider Sanction Committee may consider the need to maintain member access to services when making a determination related to convictions or sanctions described in Subsection R414-22-3(4), (5), or (6).

(8) The Provider Sanction Committee may use any grounds described in Section R414-22-4 to exclude providers from Medicaid.

(9) The Department may exclude a prospective Medicaid provider who has a current suspension from DOPL or another state's equivalent agency.

(10) The Provider Sanction Committee may exclude a prospective provider for significant misconduct or substantial evidence of misconduct that creates a substantial risk of harm to the Medicaid program.

(11) If after review, the Provider Sanction Committee finds there is prior misconduct outlined in Section R414-22-3 or Section R414-22-4, the committee retains discretionary authority to not renew a provider agreement, to not reinstate a provider agreement, and to not enroll a provider until the provider has completed all requirements deemed necessary by the committee.

R414-22-4. Grounds for Sanctioning Providers.

The Department may impose sanctions against a provider who:

(1) knowingly presents, or cause to be presented, to Medicaid any false or fraudulent claim, other than simple billing errors, for services or merchandise; or

(2) knowingly submits, or cause to be submitted, false information for the purpose of obtaining greater Medicaid reimbursement than the provider is legally entitled to; or

(3) knowingly submits, or cause to be submitted, for Medicaid reimbursement any claims on behalf of a provider who has been terminated or suspended from the Medicaid program, unless the claims for that provider were included for services or supplies provided prior to his suspension or termination from the Medicaid program; or

(4) knowingly submits, or cause to be submitted, false information for the purpose of meeting Medicaid prior authorization requirements; or

(5) fails to keep records that are necessary to substantiate services provided to Medicaid recipients; or

(6) fails to disclose or make available to the Department, its authorized agents, or the State Medicaid Fraud Control Unit, records or services provided to Medicaid members or records of payments made for those services; or

(7) fails to provide services to Medicaid members in accordance with accepted medical community standards as adjudged by either a body of peers or appropriate state regulatory agencies; or

(8) breaches the terms of the Medicaid provider agreement; or

(9) fails to comply with the terms of the provider certification on the Medicaid claim form; or

(10) overutilizes the Medicaid program by inducing, providing, or otherwise causing a Medicaid member to receive services or merchandise that is not medically necessary; or

(11) rebates or accepts a fee or portion of a fee or charge for a Medicaid member referral; or

(12) violates the provisions of the Medical Assistance Act under Title 26, Chapter 18, or any other applicable rule or regulation; or

(13) knowingly submits a false or fraudulent application for Medicaid provider status; or

(14) violates any laws or regulations governing the conduct of health care occupations, professions, or regulated industries; or

(15) is convicted of a criminal offense relating to performance as a Medicaid provider; or

(16) conducts a negligent practice resulting in death or injury to a patient as determined in a judicial proceeding; or

(17) fails to comply with standards required by state or federal laws and regulations for continued participation in the Medicaid program; or

(18) conducts a documented practice of charging Medicaid members for Medicaid covered services over and above amounts paid by the Department unless there is a written agreement signed by the member that such charges will be paid by the member; or

(19) refuses to execute a new Medicaid provider agreement when doing so is necessary to ensure compliance with state or federal law or regulations; or

(20) fails to correct any deficiencies listed in a Statement of Deficiencies and Plan of Correction, CMS Form 2567, in provider operations within a specific time frame agreed to by the Department and the provider, or pursuant to a court or formal administrative hearing decision; or

(21) is suspended or terminated from participation in Medicare for failure to comply with the laws and regulation governing that program; or

(22) fails to obtain or maintain all licenses required by state or federal law to legally provide Medicaid services; or

(23) fails to repay or make arrangements for repayment of any identified Medicaid overpayments, or otherwise erroneous payments, as required by the State Plan, court order, or formal administrative hearing decision.

(24) The Department may sanction a Medicaid provider who has a current suspension from DOPL or another state's equivalent agency.

(25) The Provider Sanction Committee may sanction a provider for significant misconduct or substantial evidence of misconduct that creates a substantial risk of harm to the Medicaid program.

(26) If after review, the Provider Sanction Committee finds there is prior misconduct outlined in Section R414-22-3 or Section R414-22-4, the committee retains discretionary authority to not renew a provider agreement, to not reinstate a provider agreement, and to not enroll a provider until the provider has completed all requirements deemed necessary by the committee.

R414-22-5. Sanctions.

Sanctions for violating any subsection of Section R414-22-4 are:

(1) Termination from participation in the Medicaid program; or

(2) Suspension of participation in the Medicaid program.

R414-22-6. Imposition of Sanction.

(1) Before the Department decides to impose a sanction, it shall notify the provider, in writing, of:

(a) the findings of any investigation by the Department, its agents, or the Office of Inspector General of Medicaid Services; and

(b) any possible sanctions the Department may impose.

(2) Providers shall have 30 days after the notice date to respond in writing to the findings of any investigation. A written request for additional time of less than 30 days may be granted by the Department for good cause shown.

(3) The Provider Sanction Committee has the discretion to impose sanctions after receiving the provider's input.

(4) The Provider Sanction Committee may consider the following factors when determining which sanction to impose:

(a) seriousness of offense;

(b) extent of offense;

(c) history of prior violations of Medicaid or Medicare law;

(d) prior imposition of sanctions by the Department;

(e) extent of prior notice, education, or warning given to the provider by the Department pertaining to the offense for which the provider is being considered for sanction;

(f) adequacy of assurances by the provider that the provider will comply prospectively with Medicaid requirements related to the offense;

(g) whether a lesser sanction will be sufficient to remedy the problem;

(h) sanctions imposed by licensing boards or peer review groups and professional health care associations pertaining to the offense; and

(i) suspension or termination from participation in another governmental medical program for failure to comply with the laws and regulations governing these programs.

(5) When the Department decides to impose a sanction, it shall notify the provider at least ten calendar days before the sanction's effective date.

R414-22-7. Scope of Sanction.

(1) Once a provider is suspended or terminated, the Department shall only pay claims for services provided prior to the suspension or termination.

(2) The Department may suspend or terminate any individual, clinic, group, corporation, or other similar organization, who allows a sanctioned provider to bill Medicaid under the clinic, group, corporation or organization provider number.

R414-22-8. Notice of Sanction.

(1) When a provider is sanctioned for a period exceeding 15 days, the Department may notify the applicable professional society, board of registration or licensor, and federal or state agencies.

(2) Notice includes:

(a) the findings made; and

(b) the sanctions imposed.

(3) The Department shall timely notify any appropriate Medicaid member of the provider's suspension or termination from the Medicaid program.

R414-22-9. Monitoring.

(1) If the Department is aware that an applicant or provider has had an action against them related to the following issues, the applicant will be subject to additional monitoring. The issues include:

(a) claims for excessive charges;

(b) providing unnecessary services;

(c) failing to disclose required information; or

(d) a misdemeanor conviction that involves health care fraud.

(2) The Department will refer applicants or providers described in Subsection R414-22-9(1) to the Office of Inspector General of Medicaid Services to be monitored for at least six months.

R414-22-10. Provider Application.

The Department shall review any Medicaid provider agreement application for previous sanctions before approving the provider agreement.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: February 14, 2020
Notice of Continuation: November 9, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3(7)

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-515**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Long Term Acute Care

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

Section 26B-1-213 grants the Department the authority to adopt, amend, or rescind rules, and Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules.

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

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

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

The Department will continue this rule because it establishes long term acute care for Medicaid members that include provisions for member eligibility, program access, service coverage, preadmission review, continued stay review, and reimbursement.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	11/30/2022

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-515. Long Term Acute Care.
R414-515-1. Introduction and Authority.

This rule defines the scope of inpatient long-term acute care hospital (LTAC) services that are available to Medicaid members for the treatment of disorders other than mental disease.

This rule is authorized by Subsection 1886(d)(1)(B)(iv)(I) of the Social Security Act and Sections 26-1-5, 26-18-2.1, 26-18-2.3, and 26-18-3.

R414-515-2. Definitions.

(1) "Admission" means the acceptance of a Medicaid member for LTAC care and treatment when the member meets established evidence-based criteria for severity of illness and intensity of service and the required service cannot be provided in a lesser level of care

setting.

(2) "Comprehensive documentation" means applicable relevant information including a history and physical, operative reports, daily physician progress notes, vital signs, laboratory test results, medications administration records, respiratory therapy notes, wound care notes, nutrition notes, physical therapy notes, occupational therapy notes, speech therapy notes, and any other pertinent information the Division needs to make a decision regarding the LTAC request.

(3) "Continued stay review" means a periodic, supplemental, or interim review of clinical information for an LTAC member.

(4) "Inpatient" means an individual whose severity of illness and intensity of service meet the evidence-based criteria for an LTAC stay.

(5) "Intensity of Service" means measure of the number, technical complexity, or attendant risk of services provided.

(6) "Long-term acute care hospital" or "Long-term care hospital" (LTAC) means an inpatient transitional care hospital designed to treat members with multiple, serious medical conditions requiring intense, acute care as determined by a physician.

(7) "Retroactive review" means a review of clinical information for a patient who had previously been admitted to an LTAC, but never received a prior authorization for the initial or continued stay due to retroactive eligibility approval.

(8) "Severity of Illness" means the extent of organ system derangement or physiologic decompensation for a patient.

R414-515-3. Client Eligibility Requirements.

A patient must be eligible for Medicaid services.

R414-515-4. Program Access Requirements.

(1) A member must meet the severity of illness and intensity of service for LTAC level of care as determined through an evidence-based criteria review process.

(a) The Department shall deny an LTAC request for reimbursement if the member does not meet the evidence-based criteria.

(b) The evidence-based criteria subsets must be utilized correctly (e.g., the primary diagnosis may not additionally be used as a secondary diagnosis).

(2) LTAC preadmissions, continued stays, and retroactive stays that do not meet the evidence-based criteria subsets may be forwarded for secondary medical review if:

(a) the LTAC requests the secondary medical review; or

(b) documentation shows that LTAC is the most appropriate level of care for the member.

R414-515-5. Service Coverage.

(1) An LTAC provider must submit to the Department a request for coverage that includes current and comprehensive documentation, or the Department will return the request as incomplete.

(2) The Department shall consider LTAC coverage upon the date it receives the request and current, comprehensive documentation.

(3) The Department shall review the documentation to determine preadmission, continued stay, or retroactive stay within three business days of the request.

(4) Prior authorization is not transferable from one LTAC to another.

(5) Prior authorization is required for preadmission, continued stay, and retroactive reviews.

(6) If a member transfers from an LTAC to an acute care hospital for any reason, and is away from the LTAC for greater than 24 hours, the LTAC shall submit a new preadmission review before transferring the member back to the LTAC.

(7) Each approved prior authorization is for a seven-day period.

R414-515-6. Preadmission Review.

An LTAC provider shall submit prior authorization requests to the Department at least 24 hours before the expected admission.

R414-515-7. Continued Stay Review.

An LTAC provider shall submit prior authorization requests to the Department two days before the end of the approved period. The continued stay prior authorization request must include all pertinent medical record comprehensive documentation supporting the evidence-based LTAC continued stay review.

R414-515-8. Reimbursement Methodology.

Reimbursement for LTAC is in accordance with the Utah Medicaid State Plan.

KEY: Medicaid, long term acute care, LTAC
Date of Enactment or Last Substantive Amendment: March 21, 2019
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3