# DIH Rules Matrix 10-22-26

| Rule Summary | Bulletin Publication | Effective |
|---|---|---|
| **R414-2A Inpatient Hospital Services (Repeal and Readopt);** This amendment clarifies the 30-day readmission policy for Medicaid members admitted to inpatient hospitals, the requirements of the repealed rule are updated and clarified in the readopted rule. Updated language restructures rule authority, adds new definitions, clarifies eligibility requirements, restructures hospital admission requirements, restructures provisions for inpatient psychiatric care, updates coverage and limitations, updates routine and ancillary services, removes provisions for provider-preventable conditions, updates provisions for utilization control, updates provisions for cost sharing, and describes provisions to pay providers. | **9-15-26** | **1-1-27** |
| **R414-10 Physician Services (Five-Year Review);** The department will continue this rule because it provides a scope of physician services to meet Medicaid member needs, specifies member eligibility, and set forth requirements for program access. | **10-15-26** | **10-11-26** |
| **R414-11 Podiatric Services;** This amendment implements by rule Medicaid policy for podiatric services that includes requirements for eligibility, requirements for program access, service coverage, and reimbursement. | **9-15-26** | **10-22-26** |
| **R414-60 Medicaid Policy for Pharmacy Program;** This amendment updates and clarifies definitions, drug coverage, coverage limitations, reimbursement, and policies for new drugs, over-the-counter drugs, compounds, and provider-administered drugs. | **10-15-26** | **11-23-26** |
| **R414-302-8 Application for Other Possible Benefits;** In accordance with the mandate set forth by the Office of Refugee Resettlement, this amendment implements a change in policy that no longer requires an individual to apply for other financial benefits before applying for Medicaid. It also removes provisions for modified adjustment gross income and Veterans Administration benefits that no longer apply to this rule. | **10-15-26** | **11-23-26** |
| **R414-340 Health Care Transparency and Accountability;** In accordance with HB 566, 2026 General Session, this rule establishes procedures for the Division of Integrated Healthcare (division) to develop and maintain a Medicaid data dashboard with information furnished by managed care plans. It also sets forth obligations for risk contractors and subcontractors regarding dashboard data submissions, improper payment identification and remediation, and sanctions for noncompliance by risk contractors of related requirements. | **9-15-26** | **11-1-26** |
| **R414-510 Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education (Five-Year Review);** The department will continue this rule because it implements the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF) voluntary transition program, which allows an individual to transition from a privately owned ICF to the Community Transitions Waiver. Without this rule, state oversight of this transition program would decrease and leave vulnerable populations at risk. | **10-1-26** | **9-2-26** |

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

**State of Utah**
**Administrative Rule Analysis**
Revised May 2026

| NOTICE OF SUBSTANTIVE CHANGE | |
|---|---|
| **TYPE OF FILING:** Repeal and Readopt | **Filing ID: OFFICE USE ONLY** |
| **Rule or section number:** | **R414-2A** |
| **Date of previous publication (only for CPRs):** | |

**1. Agency Information**

| | |
|---|---|
| **Title catchline:** | Health and Human Services, Integrated Healthcare |
| **Building:** | Cannon Health Building |
| **Street address:** | 288 N. 1460 W. |
| **City, state:** | Salt Lake City, UT |
| **Mailing address:** | PO Box 143325 |
| **City, state and zip:** | Salt Lake City, UT 84114-3325 |

**2. Contact Persons**

| Name: | Phone: | Email: |
|---|---|---|
| Craig Devashrayee | 801-915-4493 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |

**Please address questions regarding information on this notice to the persons listed above.**

**3. General Information**

**A. Rule or section catchline:**

R414-2A. Inpatient Hospital Services.

**B. Purpose of the new rule or reason for the change:**

Based on an audit received from the Utah Office of Inspector General, the Department of Health and Human Services (department) determined this change is appropriate to clarify the 30-day readmission policy for Medicaid members admitted to inpatient hospitals.

**C. Summary of the new rule or change:**

To clarify the 30-day readmission policy for Medicaid members admitted to inpatient hospitals, the requirements of the repealed rule are updated and clarified in the readopted rule. Updated language restructures rule authority, adds new definitions, clarifies eligibility requirements, restructures hospital admission requirements, restructures provisions for inpatient psychiatric care, updates coverage and limitations, updates routine and ancillary services, removes provisions for provider-preventable conditions, updates provisions for utilization control, updates provisions for cost sharing, and describes provisions to pay providers.

**4. Legislative Action Information**

| | |
|---|---|
| **A. Are any changes in this filing because of state legislative action?** | Changes are not because of legislative action. |
| **B. If yes, any bill number and session:** | |

**5. Fiscal Information**

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

**A. State budget:**

The department does not anticipate a fiscal impact to the state budget because the readopted rule solely clarifies existing guidance on when Medicaid would cover a 30-day hospital readmission to the same hospital or an affiliated hospital within 30 calendar days of discharge from a prior inpatient admission.

**B. Local governments:**

The department does not anticipate a fiscal impact to local governments because they neither fund nor provide inpatient hospital services under the Medicaid program.

| **C. Small businesses** ("small business" means a business employing 1-49 persons)**:** |
|---|
| The department does not anticipate a fiscal impact to small businesses because the hospital provisions in this rule do not apply to this group. |
| **D. Non-small businesses** ("non-small business" means a business employing 50 or more persons)**:** |
| The department does not anticipate a fiscal impact to hospitals that are non-small businesses because the readopted rule solely clarifies existing guidance on when Medicaid would cover a 30-day hospital readmission to the same hospital or an affiliated hospital within 30 calendar days of discharge from a prior inpatient admission. |
| **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***)**:** |
| The department does not anticipate a fiscal impact to other persons and entities because the readopted rule solely clarifies existing guidance on when Medicaid would cover a 30-day hospital readmission to the same hospital or an affiliated hospital within 30 calendar days of discharge from a prior inpatient admission. |
| **F. Compliance costs for affected persons:** |
| The department does not anticipate any compliance costs for any single affected person or entity because the readopted rule solely clarifies existing guidance on when Medicaid would cover a 30-day hospital readmission to the same hospital, or an affiliated hospital within 30 calendar days of discharge from a prior inpatient admission. |

**6. Regulatory Impact Summary Table**

Enter the cost or savings in the relevant cell. If there is no cost or savings, enter, "$0." If a cost or savings is inestimable, enter, "inestimable."

| **Fiscal Cost** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
|---|---|---|---|---|---|
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Cost** | **$** | **$** | **$** | **$** | **$** |
| **Fiscal Benefits** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Benefits** | $0 | $0 | $0 | $0 | $0 |
| **Net Fiscal Benefits** | $0 | $0 | $0 | $0 | $0 |

**7. Regulatory Impact Analysis Approval**

The Commissioner of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

**8. Family Impact Information**

| **A. The agency has considered this rule's impact on family health, stability, and formation:** | ☒ |
|---|---|

| **B. Summary of reasonable alternatives or modifications:** |
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**9. Citation Information**

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

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

**10. Incorporation by Reference Information**

| **Incorporation by Reference** (if this rule incorporates more than two items by reference, please include additional tables)**:** | |
|---|---|
| **A. This rule adds or updates the following title of material incorporated by reference** (a copy of the material 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 or updates the following title of material incorporated by reference** (a copy of the material 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** | |

**11. Public Notice Information**

| **The public may submit written or oral comments to the agency identified in box 1.** | |
|---|---|
| **A. Comments will be accepted until:** | 08/14/2026 |

| **B. A public hearing (optional) will be held** (The public may request a hearing by submitting a written request to the agency, as outlined in Section 63G-3-302 and Rule R15-1.)**:** | | |
|---|---|---|
| **Date:** | **Time** (hh:mm AM/PM)**:** | **Place** (physical address or URL)**:** |
| | | |

**To the agency:** If more than one hearing is planned to take place, continue to add rows.

**12. Effective Date Information**

| **This rule change MAY become effective on:** (NOTE: This is the date the agency anticipates making the filing effective. It is NOT the effective date) | 08/21/2026 |
|---|---|

**13. Agency Authorization Information**

| **To the agency**: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date. | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Commissioner | **Date:** | 08/29/2026 |

**R414. Health and Human Services, Integrated Healthcare.**
**R414-2A. Inpatient Hospital Services.[**
~~**R414-2A-1. Introduction and Authority.**~~
~~This rule defines the scope of inpatient hospital services that are available to Medicaid members. This rule is authorized under Section 26B-3-108 and governs the services allowed under 42 CFR 440.10.~~

~~**R414-2A-2. Definitions.**~~
~~(1) "Admission" means the acceptance of a Medicaid member for inpatient hospital care and treatment when the member meets established criteria for severity of illness and intensity of service and the required service cannot be provided in an alternative setting.~~
~~(2) "Inpatient" is an individual whose severity of illness and intensity of service requires continuous care in a hospital.~~
~~(3) "Inpatient Hospital Intensive Physical Rehabilitation" means an intense program of physical rehabilitation provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.~~
~~(4) "Inpatient Hospital Services" are services that a hospital provides for the care and treatment of inpatients.~~
~~(5) "Observation services" means services, often less than 24 hours, including use of a bed and monitoring by hospital staff, which are reasonable and necessary to evaluate the medical condition or determine the need for a possible admission to the hospital.~~

(6) "Prepaid Mental Health Plan" means the Medicaid mental and/or substance use disorder managed care plan that covers inpatient and/or outpatient mental health services and outpatient substance use disorder services for PMHP-enrolled Medicaid members.

**R414-2A-3. Member Eligibility Requirements.**

Inpatient hospital services are available to categorically and medically needy individuals.

**R414-2A-4. Hospital Admission Requirements.**

(1) An inpatient hospital must meet Medicare participation requirements.

(2) Each hospital that provides inpatient services must have a utilization review plan as described in 42 CFR 482.30.

(3) Each hospital that accepts a Medicaid member for treatment is responsible to verify that the member receives all medically necessary services from Medicaid providers.

(4) Each hospital is financially responsible for any services a member receives from a non-Medicaid provider.

(5) Inpatient hospital intensive physical rehabilitation participation is subject to 42 CFR 482.56 and 42 CFR 412, Subpart B and Subpart P.

**R414-2A-5. Prepaid Mental Health Plan.**

Before admitting a Prepaid Mental Health Plan (PMHP) member for an inpatient psychiatric stay, a hospital must obtain prior authorization from the PMHP serving the member's county of residence. If the hospital is not contracted with the PMHP, the PMHP may choose to transfer the member to a contracted hospital.

**R414-2A-6. Service Coverage.**

(1) Inpatient hospital services must be medically necessary and ordered by an appropriate Medicaid-enrolled provider for the diagnosis and treatment of a member's illness.

(2) Services performed for a member by the admitting hospital or by an entity wholly-owned or wholly-operated by the hospital within three days of patient admission, are considered inpatient services. This three-day window applies to diagnostic and non-diagnostic services that are clinically related to the reason for the member's inpatient admission regardless of whether the inpatient, outpatient, or observation diagnoses are the same.

(3) Medical supplies, appliances, drugs, and equipment required for the care and treatment of a member during an inpatient stay are included in the inpatient reimbursement.

(4) Outpatient hospital services during an inpatient episode are included in the inpatient reimbursement.

(5) Inpatient hospital psychiatric services are available to all Medicaid members. If the member is not enrolled in a PMHP, providers may bill the State directly on a fee-for-service basis. Otherwise, the provider must bill the member's PMHP.

(6) Inpatient hospital intensive physical rehabilitation services must meet the classification criteria of 42 CFR 412.29.

(7) Inpatient hospital intensive physical rehabilitation services are covered for acute conditions from birth through any age and are available one time per event.

**R414-2A-7. Limitations.**

Inpatient hospital care is limited to medical treatment of symptoms that lead to medical stabilization of the member. This medical stabilization care is irrespective of any underlying psychiatric diagnosis.

(1) Detoxification for a substance use disorder in a hospital shall meet the criteria in the Department's evidence-based criteria tool for inpatient detoxification. The Department does not cover any lesser level of detoxification in an inpatient hospital. The standards for the evidence-based criteria tool shall be in accordance with Section R414-1-12.

(2) Abortion procedures require prior authorization. Refer to Rule R414-1B.

(3) Sterilization and hysterectomy procedures require prior authorization and must meet the requirements of 42 CFR 441, Subpart F.

(4) Organ transplant services are governed by Rule R414-10A.

(5) Take-home supplies, dressings, non-rental durable medical equipment, and drugs are included in the inpatient reimbursement.

(6) Coverage of sleep studies requires sleep center accreditation through one of the following nationally recognized accreditation organizations:

(a) American Academy of Sleep Medicine (AASM);

(b) Accreditation Commission for Health Care (ACHC); or

(c) The Joint Commission (TJC).

(7) Hyperbaric oxygen therapy is limited to service in a facility in which the hyperbaric unit is accredited by the Undersea and Hyperbaric Medical Society. Hyperbaric oxygen therapy is therapy that places the member in an enclosed pressure chamber for medical treatment.

(8) Medicaid does not cover inpatient services solely for pain management. Pain management is adjunct to other Medicaid services.

(9) Inpatient rehabilitation services require prior authorization.

(10) Observation services are limited to cases where observation and evaluation is required to establish a diagnosis and determine the appropriateness of an inpatient admission or discharge. Observation is used to monitor the member's condition,

complete diagnostic testing to establish a definitive diagnosis and formulate the treatment plan.

(a) Medicaid covers observation services with a physician's written order that outlines specific medically necessary reasons for the service, such as the member requires more evaluation to determine the severity of illness through laboratory, imaging, or other diagnostic test, and an order to continue monitoring for clinical signs and symptoms to determine improving or declining health status.

(b) Outpatient procedures include an uneventful recovery period.

(i) Observation is used to monitor complications of outpatient procedures beyond an uneventful recovery period.

(c) Medicaid does not cover observation services for convenience of the hospital, member or family, or when awaiting transfer to another facility.

(d) When an ordered hospital inpatient admission improves to the point of discharge with a stay less than 24 hours, the admission is covered as inpatient when documentation supports the medical necessity.

(e) Inpatient admissions solely for observation or diagnostic evaluation do not qualify for reimbursement under the diagnosis-related group (DRG) system.

(11) Medicaid does not cover admission solely for the treatment of eating disorders.

(12) Medicaid does not cover non-physician psychosocial counseling outside of the DRG.

(13) An undocumented immigrant who does not meet United States residency requirements may only receive emergency services, including emergency labor and delivery, to treat an emergency medical condition.

(a) Medicaid does not cover prenatal and post-partum services for undocumented immigrants.

(b) Medicaid does not cover prescriptions for a member who is eligible to receive emergency services only.

(14) Inpatient hospital intensive physical rehabilitation services are not covered when the condition and prognosis meet the requirements of placement into a long-term facility, skilled nursing facility, or outpatient rehabilitation service.

(15) Medicaid does not cover admission for deconditioning in an inpatient hospital intensive physical rehabilitation facility.

(16) Inpatient hospital intensive physical rehabilitation services for a member who has suffered a stroke or other cerebral vascular accident may be provided only when admission and therapy is initiated within the first 60 days after onset of the incident.

**R414-2A-8. Provider-Preventable Conditions.**

(1) Medicaid does not pay for Provider Preventable Conditions (PPC).

(a) Medicaid utilizes the Medicaid Severity Diagnosis Related Group (MS-DRG) to identify a PPC.

(b) For inpatient hospital claims, Medicaid does not cover PPCs in Medicare crossover patients.

(c) To qualify as a PPC, one of the Medicare-listed diagnoses must develop during hospitalization.

(i) When present on admission, these diagnoses are not considered to be a PPC for that hospitalization.

(ii) Providers are expected to identify Present on Admission (POA) status for all diagnoses on each claim according to correct coding standards.

(d) Providers must assure that all PPC-related diagnoses, services, and charges are noted as "non-covered charges" on the claim.

(i) The Department does not use non-covered charges in calculating the hospital reimbursement.

(e) The Department shall deny PPC-related claims that result in an outlier payment and medical records will be required.

(i) Providers will receive Remittance Advice (RA) that confirms the occurrence of a PPC outlier claim.

(ii) The Department requires providers to know which medical records and other required documents are needed.

(iii) Upon RA notification of a PPC, the provider shall submit the following documents within 30 days:

(A) "Outlier PPC Medical Record Documentation Submission Form";

(B) Complete medical records from the associated hospital stay;

(C) Itemized bill (tab de-limited text file or Excel spreadsheet), including a detailed listing of PPC-related charges as non-covered charges, with total charges matching the total charges submitted on the claim.

(f) The Department will review and, if appropriate, re-process the claim based upon the review of the required documents submitted within the 30-day period of RA notification.

(g) The Department shall deny review of the claim unless the required documentation is submitted within 30 days of RA notification.

(h) The Department requires providers to report PPCs in accordance with Section R414-1-28.

**R414-2A-9. Reporting Routine Services.**

Routine services in a hospital must be included in a daily service charge, also referred to as room and board. These types of routine services that are not separately reported include:

(1) Room;

(2) Dietary services;

(3) Nursing services;

(4) Minor medical and surgical supplies;

(5) Medical and psychiatric social services;

(6) Use of hospital and facilities;

(7) Drugs, biologicals, supplies, appliances, and equipment, such as:

(a) Anything necessary or otherwise integral to the provision of a specific service, the delivery of services in a specific location, or both;

(b) Items and supplies that may be purchased over the counter;

(c) Reusable items, supplies, and equipment that are provided to all patients admitted to a given treatment area or unit receiving the same service;
(d) Certain other diagnostic or therapeutic services;
(e) Medical or surgical services provided by certain interns or residents-in-training; and
(f) Transportation services, including transport by ambulance.

**R414-2A-10. Utilization Control and Review Program for Hospital Services.**
The Hospital Utilization Review Program is administered and operated in accordance with Title 63A, Chapter 13.
(1) The purpose of the hospital utilization review program is to ensure:
(a) efficient and effective delivery of services;
(b) services are appropriate and medically necessary;
(c) service quality is maintained; and
(d) the State satisfies federal requirements for a statewide surveillance and utilization control program.
(2) The Hospital Utilization Review Program shall conduct assessments and audits to ensure the appropriateness and medical necessity of the following:
(a) Admissions to a hospital or a designated distinct part unit within a hospital;
(b) Transfers from one acute care hospital to another acute care hospital, or to an inpatient rehabilitation hospital or psychiatric unit in another acute care hospital (inter-facility transfer);
(c) Transfers from an acute care setting to an inpatient rehabilitation unit of a hospital or psychiatric unit within the same facility (intra-facility transfer);
(d) Continued stays;
(e) Services, surgical services and diagnostic procedures;
(f) Principal diagnosis, principal surgical procedure or both, reflected on paid claims to ensure consistency with the attending physician's determination and documentation as found in the member's medical record;
(g) Determine whether co-morbidity, as found on the claim, is correct and consistent with the attending physician's determination and compatible with documentation found in the member's medical record; and
(h) Quality of care.
(3) The Hospital Utilization Review Program shall conduct assessments and audits to determine:
(a) Appropriate utilization;
(b) Compliance with state and federal Medicaid regulations;
(c) Whether documentation meets state and federal requirements for sufficiency, and whether it accurately describes the status of services provided to the member; and
(d) Whether procedures that require prior authorization have been approved before the provision of services, except in cases that meet the criteria listed in the Utah Medicaid Section 1: General Information Provider Manual (Retroactive Authorization).
(4) The Hospital Utilization Review Program shall make determinations of medical necessity, appropriateness of care, and suitability of discharge planning in accordance with the following criteria and protocols:
(a) InterQual Criteria;
(b) Administrative rules or criteria developed by Medicaid for programs and services not otherwise addressed; and
(c) DRGs.
(5) Hospital Utilization Readmission Policy and Reviews.
(a) Whenever information available to the reviewer indicates the possibility of readmission to acute care within 30 days of the previous discharge, the staff administering and operating the Hospital Utilization Review Program may review any claim for:
(i) Readmission for the same or a similar diagnosis to the same hospital, or to a different hospital;
(ii) Appropriateness of inter-facility transfers; and
(iii) Appropriateness of intra-facility transfers.
(b) The Hospital Utilization Review Program shall review all suspected readmissions within 30 days of a previous discharge to ensure that Medicaid criteria have been met for severity of illness, intensity of service, and appropriate discharge planning and financial impact to the Department as noted in Subsection R414-2A-10(3).
(c) If a member is readmitted for the same or similar diagnosis within 30 days of discharge and, if after review as described in Subsection R414-2A-10(5)(b), program review staff determines that readmission does not meet the criteria in Subsection R414-2A-10(3)(b), then the payment shall be combined into a single DRG payment, unless it is cost effective to pay for two separate admissions. The first DRG (initial admission) shall be the DRG that is paid. This policy does not apply to cases related to pregnancy, neonatal jaundice, or chemotherapy.
(6) Definition, Policy Application.
(a) When applying policy, a similar diagnosis is defined as:
(i) Any diagnoses code with similar descriptors;
(ii) Any exchange or combination of principal and secondary diagnosis; and
(iii) Any other sets of principal diagnoses established to be similar by Utah Medicaid policy in written criteria and published to the hospitals prior to service dates.
(b) The evaluation criteria for utilization control are severity of illness, intensity of service, and cost effectiveness as noted in Subsection R414-2A-10(5)(b).
(7) Appropriate remedial action will be initiated for inappropriate readmissions when identified though the hospital

~~utilization post-payment review process.~~

~~(8) Applicability to Outpatient Hospital Services.~~

~~(a) When a Medicaid member is readmitted to the hospital, or readmitted as an outpatient within 30 days of a previous discharge for the same or similar diagnosis, Medicaid will evaluate both claims to determine if they should be combined into a single payment or paid separately.~~

~~(9) Recovery of Funds.~~

~~(a) The Department shall recover payment when post-payment review finds that services are not medically necessary, not appropriate, or that quality of service is not suitable.~~

~~(b) The Department shall recover payment when it determines there is a violation of the 30-day re-admission policy.~~

~~(10) Hospital Utilization Review.~~

~~(a) Each month, the Hospital Utilization Review Program shall review at least 5 percent of a selected universe of claims adjudicated in the previous month. At least 2.5 percent of the claims shall be a random sample. Up to 2.5 percent may be a focused review on a specific service. A staff decision to focus on a specific service shall be made no later than the beginning of the sample cycle.~~

~~(b) The Department shall select the universe from paid inpatient hospital claims within the Data Warehouse. The universe from which the random sample is selected is defined as all inpatient hospital claims adjudicated before the beginning of the review cycle, except for:~~

~~(i) Claims showing, as a principal diagnosis, any International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) delivery code in the ICD-10-CM Manual Chapter 15 – Pregnancy, Childbirth, and the Puerperium, in the range of O00 through O9A.53, and other ICD-10-CM codes or DRG or DRGs as specified by policy or administrative decision.~~

~~(ii) Claims that show $0 payment by Medicaid;~~

~~(iii) Medicare crossover claims;~~

~~(iv) Claims with other codes or diagnoses determined by the review program staff to be inappropriate for review.~~

~~(c) The sample cycle shall begin on the first working day of each month.~~

~~(11) Utah State Hospital Utilization Review.~~

~~(a) The purpose of this utilization review is to ensure that Medicaid funds, as defined under 42 CFR 456, Subpart D, are expended appropriately and to ensure that services provided to Medicaid members at the Utah State Hospital (USH) are necessary and of high quality. Review program staff shall conduct oversight activities at USH.~~

~~(b) Oversight activities include quarterly clinical utilization reviews in which program staff review a sample of members who are under 21 years of age and are 65 years of age or older, and who were reviewed by USH utilization review staff during a previous quarter. These reviews are performed to:~~

~~(i) Evaluate the USH utilization process; and~~

~~(ii) Address the clinical topic selected for that quarter's review.~~

~~(c) Reviews of USH Quality Improvement and Quality Assurance programs are conducted to determine whether:~~

~~(i) The programs have been implemented in accordance with written hospital policy;~~

~~(ii) The programs are effective in meeting stated goals;~~

~~(iii) Improvements or modifications have been made to increase the effectiveness of program design.~~

~~(12) Applicability to Inpatient Psychiatric Care and Inpatient Rehabilitation Services.~~

~~(a) Provisions in the Hospital Utilization Review Program also apply to inpatient psychiatric care and inpatient rehabilitation services.~~

**~~R414-2A-11. Cost Sharing.~~**

~~A Medicaid member is responsible for a copayment as established in the Utah Medicaid State Plan and incorporated by reference in Rule R414-1.~~

**~~R414-2A-12. Reimbursement.~~**

~~Reimbursement for inpatient hospital services is in accordance with Attachment 4.19-B of the Utah Medicaid State Plan, which is incorporated by reference in Rule R414-1.~~]

**R414-2A-1. Authority and Purpose.**

(1) Section 26B-3-106 authorizes this rule.

(2)(a) This rule defines the scope of inpatient hospital services available to Medicaid members and is used in conjunction with Rule R414-1, the Utah Medicaid State Plan, as incorporated by reference in Rule R414-1, and other applicable state and federal requirements for the Utah Medicaid program.

(b) This rule governs the services allowed under 42 CFR 440.10 (2026).

**R414-2A-2. Definitions.**

(1) "30-day readmission" means an inpatient admission to the same hospital or an affiliated hospital within 30 calendar days of discharge from a prior acute inpatient admission.

(2) "Admission" means the acceptance of a Medicaid member for inpatient hospital care and treatment.

(3) "Affiliated hospital" or "same hospital" means a licensed facility billing under the same employer identification number as the initial discharging hospital.

(4) "Against medical advice" means an instance when a Medicaid member chooses to leave a hospital despite documented

medical advice against discharge.

(5) "Clinically related" means a readmission for a diagnosis, condition, or complication that:

(a) is the same as, similar to, or a progression of the principal diagnosis of the initial admission;

(b) represents a known or reasonably foreseeable complication of care provided during the initial admission; or

(c) is determined by the department, based on evidence-based clinical standards and the medical record, to be causally linked to the initial admission.

(6) "Cost effectiveness" means achieving a desired outcome at the lowest possible cost while considering the definition of medically necessary service in Subsection R414-1-2(18) and how used resources align with Subsection R414-2A-9(1).

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

(8) "Discharge planning" means the process mandated by 42 CFR 482.43.

(9) "Healthy outcomes medical excellence" or "HOME" means a managed care entity operated by the University of Utah that contracts with the department to provide integrated physical health, mental health, and substance use disorder services to Medicaid members with a developmental disability and associated behavioral health needs.

(10) "Initial admission" means the original inpatient hospital stay from which the Medicaid member was discharged, which triggers the 30-day readmission review window.

(11) "Inpatient" means an individual whose severity of illness and intensity of service requires continuous care in a hospital.

(12) "Inpatient hospital intensive physical rehabilitation" means an intense program of physical rehabilitation provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.

(13) "Inpatient hospital services" means the services a hospital provides for the care and treatment of an inpatient.

(14) "Leave of absence" or "LOA" means a planned temporary absence from a hospital with the intent of returning for the continuation of the same or a similar course of treatment.

(15) "Managed care entity" means an organization that enters into a contract with the department to provide health care services to Medicaid members, which may include a managed care organization, a prepaid inpatient health plan, or a prepaid ambulatory health plan.

(16) "Medicaid Enterprise System" or "MES" means the mechanized claims processing and information retrieval system, including modular software and hardware, used by the department to manage, monitor, and administer Medicaid program operations, including transaction processing, service utilization review, and management reporting.

(17) "Non-covered day" means the portion of an acute inpatient hospital stay for which the department does not provide coverage or reimbursement, including:

(a) a day associated with an interrupted stay when a Medicaid member is discharged and subsequently returns, creating a gap in acute care services;

(b) a day categorized as custodial care, when services are provided primarily to meet personal needs or activities of daily living rather than active medical or nursing intervention;

(c) a day for services that are not approved or covered by the Utah Medicaid State Plan;

(d) a day used for Medicaid member or family convenience, including a stay extended for comfort or personal preference beyond the point of medical stability;

(e) a day when a Medicaid member is medically ready for discharge but remains in the hospital awaiting placement in a lower level of care, such as a nursing facility;

(f) a day when a Medicaid member's clinical status does not meet the established criteria for medical necessity, severity of illness, or intensity of service;

(g) a period when a Medicaid member is out of the hospital on a leave of absence; and

(h) the period between a preventable initial discharge and a subsequent readmission, as described in Section R414-2A-9.

(18) "Non-preventable readmission" means a readmission that is not a planned readmission and is not a preventable readmission, as determined through review of a medical record under Section R414-2A-9.

(19) "Observation services" means services, including use of a bed and monitoring by hospital staff, which are reasonable and necessary to evaluate the medical condition or determine the need for possible admission to the hospital.

(20) "Planned readmission" means a readmission that is scheduled or expected as part of the Medicaid member's documented plan of care for the condition treated in the initial admission, including a planned staged procedure, planned continuation of treatment, or a documented leave of absence with intent to return for continuation of the same or similar course of treatment, as supported by the medical record.

(21) "Prepaid mental health plan" or "PMHP" means a managed care entity that contracts with the department to provide mental health and substance use disorder services to a Medicaid member.

(22) "Present on admission status" or "POA status" means the status reported for each principal and secondary diagnosis to distinguish between a condition that existed at admission and a condition that developed subsequently.

(23) "Preventable readmission" means a clinically related readmission for which the department determines, based on the medical record from the initial admission and the readmission, that the provider failed to demonstrate compliance with at least one discharge-transition requirement.

(24) "Program" means the statewide surveillance and utilization control program for hospital services, administered in accordance with 42 CFR 456 and Title 63A, Chapter 13, Office of Inspector General of Medicaid Services.

(25) "Provider-preventable condition" means a condition that is:

(a) a health care-acquired condition, as defined in 42 CFR 447.26(b); or

(b) an other provider-preventable condition, as defined in 42 CFR 447.26(b), and as identified in the Utah Medicaid State

Plan.

(26) "Single episode of care payment" means the consolidation of reimbursement for an initial stay and a clinically related readmission into one prospective payment.

(27) "Utah Medicaid Integrated Care" or "UMIC" means a managed care entity that contracts with the department to provide integrated medical and behavioral health services, including mental health and substance use disorder services, to a Medicaid member.

**R414-2A-3. Medicaid Member Eligibility Requirements.**

Inpatient hospital services are available to a Medicaid member who meets the eligibility requirements established in Rule R414-1.

**R414-2A-4. Hospital Admission Requirements.**

(1) An inpatient hospital shall meet the conditions of participation, as established in 42 CFR 482.

(2) Each hospital shall ensure that services provided to a Medicaid member are medically necessary, as described in Subsection R414-1-2(18).

(a) Coverage of inpatient admissions requires the Medicaid member to meet established criteria for severity of illness and intensity of service.

(b) The required service, as described in Subsection (2)(a), cannot be provided in an alternative setting.

(3) Each hospital providing inpatient hospital services shall have a written utilization review (UR) plan, as described in 42 CFR 482.30, that provides for the review of each Medicaid member's need for the services the hospital furnishes.

(4) Each hospital shall comply with the provider and Medicaid member agreement requirements established in Section R414-1-13.

(5) For a Medicaid member receiving psychiatric services, the hospital shall ensure the admission is medically necessary, as defined in Subsection R414-1-2(18), and shall comply with the certification, recertification, and plan of care requirements described in 42 CFR 441, Subpart D.

(6) Inpatient hospital intensive physical rehabilitation participation is subject to 42 CFR 482.56 and 42 CFR 412, Subparts B and P.

**R414-2A-5. Inpatient Psychiatric Services and Managed Care.**

(1) Before admitting a Medicaid member of a PMHP for an inpatient psychiatric stay, the facility providing services must obtain prior authorization from the managed care entity responsible for the Medicaid member's psychiatric benefits. This includes:

(a) the PMHP serving the Medicaid member's county of residence; or

(b) the UMIC plan or HOME program plan in which the Medicaid member is enrolled.

(2)(a) A managed care entity is responsible for determinations of coverage and reimbursement of inpatient hospital psychiatric services for the managed care entity's enrolled Medicaid members.

(b) The department is responsible for determinations of coverage and reimbursement of admissions when a Medicaid member is not enrolled in a managed care entity responsible for psychiatric services.

(3) A managed care plan shall cover a psychiatric-related inpatient stay for a Medicaid member in accordance with the certification and recertification requirements of 42 CFR 441.152.

**R414-2A-6. Service Coverage.**

(1) Inpatient hospital services shall be medically necessary and ordered by an appropriate Medicaid-enrolled provider for the diagnosis and treatment of a Medicaid member's illness.

(2) The department covers the overall inpatient hospital services of an admitting hospital or entity wholly owned or wholly operated by a hospital within three days of admission.

(3) The three-day window established in Subsection (2) applies to diagnostic and non-diagnostic services clinically related to the reason for admission, regardless of whether the inpatient, outpatient, or observation diagnoses are the same.

(4) Services performed for a Medicaid member by the admitting hospital or an affiliated hospital within 30 calendar days of discharge from a prior acute inpatient admission for a clinically related diagnosis are subject to review as a preventable readmission or planned readmission.

(5) If the department determines the readmission is a preventable readmission or planned readmission, the claims shall be consolidated and reported as a single episode of care resulting in a single payment.

(a) The department shall determine preventable readmission in accordance with Subsection R414-2A-2(23) and Section R414-2A-9.

(b) An exception to claim consolidation may only be granted when the department determines, and documents in the program's review record, that separate reimbursement is more cost effective to the department than a single episode of care payment.

(6) Medical supplies, appliances, drugs, and equipment required for the care and treatment of a Medicaid member during an inpatient stay are included in the inpatient reimbursement.

(7) Outpatient hospital services during an inpatient episode are included in the inpatient reimbursement.

(8) Inpatient hospital psychiatric services shall be medically necessary, as defined in Subsection R414-1-2(18), and shall comply with this rule and the Utah Medicaid Hospital Services Provider Manual, as incorporated by reference in Rule R414-1.

(9) Inpatient hospital intensive physical rehabilitation services shall meet the classification criteria of 42 CFR 412.29.

(10) The department shall cover inpatient hospital intensive physical rehabilitation services for acute conditions from birth

through any age and are available one time for any given event.

**R414-2A-7. Limitations.**

(1)(a) Inpatient hospital services shall be limited to medical treatment of symptoms that lead to medical stabilization of the Medicaid member.

(b) Medical stabilization care described in Subsection (1)(a) shall be provided irrespective of any underlying psychiatric diagnosis.

(2) Detoxification in a hospital for a substance use disorder shall meet the evidence-based threshold for clinical instability criteria for inpatient detoxification.

(a) The department may not cover any lesser level of detoxification in an inpatient hospital.

(b) The standards for evidence-based thresholds for clinical instability shall be in accordance with Section R414-1-12.

(3) An inpatient hospital may only perform an abortion procedure in accordance with Rule R414-1B.

(4) An inpatient hospital may only perform a sterilization or hysterectomy procedure in accordance 42 CFR 441, Subpart F.

(5) The department shall govern organ transplant services in accordance with Rule R414-10A.

(6)(a) Take-home supplies, dressings, non-rental durable medical equipment, and drugs provided by a hospital at the time of discharge are included in the inpatient reimbursement and are not separately reportable.

(b) Subsection (6)(a) does not apply to durable medical equipment (DME) or supplies provided by an external Medicaid-enrolled DME provider for use in a Medicaid member's home after discharge.

(7) An inpatient hospital that performs sleep studies and hyperbaric oxygen therapy must follow evidence-based standards of care to qualify for determinations of inpatient coverage of services.

(8) The department does not cover inpatient hospital services solely for pain management, except when required to stabilize an emergency medical condition, as defined in Section R414-1-2. The department otherwise covers pain management adjunct to other covered services.

(9) Observation services are not an inpatient service and are governed in accordance with Rule R414-3A.

(10) The department may not cover an inpatient admission when the Medicaid member's severity of illness does not match the acuity level of care required for an inpatient stay.

(11) The department may not cover admission solely for the treatment of an eating disorder unless the Medicaid member meets the evidence-based threshold for clinical instability.

(12) The department shall govern services provided to an individual with undocumented immigration status in accordance with Rule R414-518.

(13) The department may not cover an inpatient hospital intensive physical rehabilitation services admission for deconditioning.

(14) Inpatient hospital intensive physical rehabilitation services for a Medicaid member who has suffered a stroke or other cerebral vascular injury shall be provided based on current medical necessity and clinical instability.

(15) The department may not cover an inpatient admission primarily for the provision of services determined by the department to be:

(a) experimental;

(b) investigational; or

(c) furnished outside of evidence-based standards of care.

(16) The department shall issue a technical denial when a provider fails to submit complete medical records within 30 days of a written request in accordance with Section R414-1-14.

(a) For purposes of readmission review, complete medical records must include at least:

(i) an admission history and physical;

(ii) a discharge summary;

(iii) a discharge planning documentation required under 42 CFR 482.43;

(iv) a medication reconciliation; and

(v) documentation of follow-up care for any high-risk condition.

(b) The department shall conduct the recovery of funds resulting from a technical denial in accordance with Section R414-1-14.

(17) The department may not cover or reimburse a provider-preventable condition in accordance with 42 CFR 447.26 and Attachment 4.19-A of the Utah Medicaid State Plan.

**R414-2A-8. Routine and Ancillary Services.**

(1)(a) Routine services, including supplies, items, or services integral to a Medicaid member's care or specific service delivery, are comprised in the daily room and board facility charge and are not be reported separately. An inpatient hospital shall provide these services in accordance with the definition of inpatient hospital services ordinarily furnished in a hospital under 42 CFR 440.10 and 42 CFR 409, Subpart B.

(b) Additional reporting requirements are maintained in the Utah Medicaid Hospital Services Provider Manual.

(2) Services that may be reported separately from the inpatient hospital facility payment are outlined in 42 CFR 409, the Utah Medicaid State Plan, and the Utah Medicaid Hospital Services Provider Manual.

**R414-2A-9. Statewide Surveillance and Utilization Control Program for Hospital Services.**

The program is administered and operated in accordance with Title 63A, Chapter 13, Office of Inspector General of Medicaid Services, and 42 CFR 456.

(1) The department shall implement a statewide program of surveillance and utilization control for hospital services that meets the state and federal requirements to:

(a) safeguard against unnecessary or inappropriate use of Medicaid services and excess payments;

(b) ensure that each hospital furnishing inpatient hospital services has a written UR plan that provides for the review of an individual's need for the services the hospital furnishes;

(c) conduct ongoing evaluations of the medical necessity, appropriateness, cost effectiveness, and quality of inpatient hospital services, including medical record reviews to verify physician certifications and plans of care services are appropriate, cost effective, and medically necessary;

(d) promote the most effective and efficient use of available health facilities and services consistent with individual needs and professionally recognized standards of health care;

(e) initiate appropriate remedial action or recovery of funds when a review identifies:

(i) inappropriate utilization;

(ii) substandard quality of care;

(iii) inadequate discharge planning that did not include assessment of:

(A) post-discharge needs;

(B) functional status;

(C) necessary follow-up care; and

(D) community resources; or

(iv) a failure to comply with state and federal Medicaid regulations.

(2) The program shall conduct assessments and audits to ensure medical necessity, appropriate utilization, and cost effectiveness of:

(a) each admission to a hospital or a designated distinct part unit, including a review of any suspected 30-day readmission to determine clinical relatedness and preventability within a hospital;

(b) each inter-facility transfer between acute care hospitals, inpatient rehabilitation hospitals, or psychiatric units;

(c) each intra-facility transfer from an acute care setting to a specialized unit within the same facility;

(d) evaluation of whether the medical record demonstrates safe discharge, including whether discharge planning complied with 42 CFR 482.43 and whether documentation supports separate reimbursement for a subsequent clinically related admission, as described in Subsection (5);

(e) coding and documentation integrity that:

(i) match the attending physician's documentation in the medical record;

(ii) verify any principal diagnosis and surgical procedure; and

(iii) verify the accuracy of POA status for every principal and secondary diagnosis to determine if the cause of readmission developed post-discharge; and

(f) ongoing review to ensure services are safely administered, evidence-based, and patient-centered.

(3) The program shall conduct assessments and audits to determine appropriate utilization, such as:

(a) compliance, including:

(i) adherence to state and federal Medicaid regulations; and

(ii) compliance with the department's published policies and procedures, including the Utah Medicaid Hospital Services Provider Manual;

(b) cost effectiveness;

(c) medical necessity, as defined in Subsection R414-1-2(18);

(d) whether documentation meets state and federal requirements for sufficiency, accurately describes the status of services provided to the Medicaid member, and includes mandatory post-discharge reporting for high-risk conditions; and

(e) whether procedures that require prior authorization have been approved before the provision of services.

(4) Exceptions to the program requirement to conduct assessments and audits to determine appropriate utilization must be in accordance with the policies outlined in the Utah Medicaid Section I: General Information Provider Manual, incorporated by reference in Rule R414-1.

(5) The program shall make determinations of medical necessity, appropriateness of care, cost effectiveness, and suitability of discharge planning in accordance with:

(a) standardized clinical review criteria used to assess whether a readmission is clinically related and the medical record demonstrates compliance with discharge-transition requirements material to safe discharge, including discharge planning, care coordination, medication reconciliation, follow-up arrangements, and access to post-acute care when clinically indicated;

(b) the clinically based, patient-focused medical review determined by the department;

(c) rule or criteria developed by the department for any program or service not otherwise addressed by evidence-based tools;

(d) the prospective payment methodology and clinical logic used to categorize inpatient stays; and

(e) requirements that:

(i) each clinical review tool, standardized criteria, and payment logic used by the program to evaluate medical necessity, preventability, or cost effectiveness is applied to inform, but does not supplant, the department's regulatory authority under this rule;

(ii) each determination of coverage, reimbursement, consolidation of claims, and recovery of funds is governed by rule, the Utah Medicaid State Plan, and applicable federal law;

(iii) in determining whether a readmission is preventable, the program shall evaluate if the medical record demonstrates, as clinically indicated for the Medicaid member's condition:

(A) that inpatient hospital level of care was no longer medically necessary at the time of discharge and that discharge to the next setting of care was appropriate;

(B) discharge planning consistent with 42 CFR 482.43, including timely identification of post-discharge needs, discharge planning evaluation, and inclusion of the evaluation in the medical record;

(C) documented care coordination, medication reconciliation, transmission of necessary clinical information, or timely follow-up arrangements needed for safe discharge; or

(D) documented patient or caregiver education, or access to medically necessary post-acute services, supplies, or community-based supports, needed for safe discharge; and

(iv) the department's determination of a preventable readmission shall be based on the presence, absence, insufficiency, or untimely completion of documentation in the medical record and on whether the documented discharge process reasonably supports separate reimbursement for the later admission.

(6)(a) The program shall review any readmission to an affiliated hospital or the same hospital, as defined in Section R414-2A-2, occurring within 30 days of a previous discharge from an admission.

(b)(i) The program shall evaluate each readmission to ensure compliance with Medicaid criteria for clinical stability at discharge and the adequacy of discharge planning in accordance with Subsection (5).

(ii) The department shall determine whether a readmission is preventable if the medical record does not demonstrate discharge planning consistent with 42 CFR 482.43.

(c) If a Medicaid member is readmitted for the same or a clinically related diagnosis, as defined in Section R414-2A-2, the department shall require the billing entity to combine the initial and readmission claims into a single episode of care, resulting in a consolidated diagnosis-related group (DRG) payment, if the department determines that the readmission is:

(i) a planned readmission, including a leave of absence; or

(ii) a preventable readmission based on the standards in Subsection (5).

(d) The department shall exempt a 30-day readmission from claims consolidation, and allow separate reimbursement, for the following exception and exclusion categories:

(i) a transfer to a different facility billing under a different taxpayer identification number for a higher level of care;

(ii) an admission to specialized, non-acute inpatient facility types that include:

(A) an inpatient rehabilitation facility or designated unit;

(B) a psychiatric inpatient facility;

(C) a long-term acute care hospital;

(D) a critical access hospital; or

(E) a cancer specialty hospital;

(iii) a planned therapeutic admission for chemotherapy, radiation, dialysis, or blood transfusion;

(iv) a high-risk complex clinical condition that includes:

(A) sickle cell disease, trait, or anemia;

(B) hepatic failure or cirrhosis of the liver; or

(C) a complication of a transplanted organ or tissue;

(v) an obstetrical admission;

(vi) a neonatal or newborn admission; or

(vii) a readmission in which a patient left the initial admission against medical advice.

(e) The department shall only reimburse a 30-day readmission as a separate claim if:

(i) the readmission is determined to be a non-preventable readmission; or

(ii) the diagnosis falls under a specific exclusion category defined in the Utah Medicaid Hospital Services Provider Manual.

(f) Any exclusion category referenced in the Utah Medicaid Hospital Services Provider Manual shall be:

(i) published before the dates of service under review;

(ii) applied uniformly to similarly situated providers; and

(iii) consistent with the authority granted under this rule.

(g) The program shall retain written justification supporting the determination for audit and appeal purposes when the department authorizes separate reimbursement under a cost effectiveness exception.

(7) The department may apply this rule through both pre-payment and post-payment mechanisms, including claim edits, manual reviews, audits, and recovery actions, in accordance with 42 CFR Part 456 and Section R414-1-14.

(a) The department shall use pre-payment mechanisms, including any programmatic edit and claim review process within the MES, to identify any potential 30-day readmission and ensure each claim is appropriately reviewed before payment in accordance with this rule.

(b) The program shall conduct post-payment monitoring to identify any:

(i) inappropriate readmission;

(ii) unauthorized transfer;

(iii) failure to comply with documentation standards; or

(iv) noncompliance with this rule.

(c) The department shall recover payment for a subsequent admission when the program determines:

(i) the readmission violated the single episode of care payment requirements;

(ii) the readmission was a planned readmission;
(iii) the readmission was a preventable readmission, based on the standards in Subsection R414-2A-2(23); or
(iv) the provider failed to comply with mandatory discharge planning, documentation, or reporting requirements for a high-risk condition.
(8)(a) The program shall initiate appropriate remedial action when post-payment monitoring or a utilization review identifies an inappropriate readmission, unauthorized transfer, or pattern of noncompliance with the single episode of care payment requirements.
(b) Remedial action may include:
(i) directing the provider to correct a billing error through claim adjustment and consolidation;
(ii) implementation of a provider-specific proactive pre-payment review strategy for future claims; or
(iii) the department conducting recovery of funds for any overpayment identified during the review process in accordance with Section R414-1-14.
(c) When the program identifies a systemic pattern of preventable readmissions or inadequate discharge planning, the department may require the provider to develop and implement a formal quality improvement plan to address any root cause of care transition failure.
(9) As applied to outpatient hospital services, a Medicaid member who is readmitted to the hospital as an inpatient or treated in an outpatient hospital setting within 30 days of a previous discharge for the same or clinically related diagnosis, the program shall evaluate both claims.
(10)(a) The department shall recover payment when the program finds that:
(i) services are not medically necessary;
(ii) services are not medically appropriate, as defined in Section R414-1-2, including experimental, investigational, or unproven practices described in Rule R414-1A, unless such practices are part of a qualifying clinical trial, as defined in Section 210 of the Consolidated Appropriations Act of 2021 and the Utah Medicaid Section I: General Information Provider Manual; or
(iii) the quality of service is not aligned with evidence-based standards of care.
(b) The department shall recover payment when a review determines there is a violation of the 30-day readmission policy described in Subsection (6), including:
(i) a readmission that violates the single episode of care payment requirements described in Subsection (5), including a readmission for which the medical record does not demonstrate compliance with discharge-transition requirements material to safe discharge;
(ii) failure of a provider to combine claims for a planned readmission or a preventable readmission into a single episode of care payment; or
(iii) failure to comply with documentation or reporting requirements.
(c) If the department determines a readmission is a preventable readmission or planned readmission, the provider shall cancel the original separate claim and resubmit a consolidated claim to receive reimbursement in accordance with the department's billing instructions.
(d) The department shall conduct recovery of funds in accordance with the overpayment and refund procedures established in Section R414-1-14.
(i) A provider shall refund the payment upon written request from the department.
(ii) If a provider refuses to grant access to records or services cannot be verified:
(A) the provider shall refund the funds; or
(B) the department may deduct an equal amount from a future reimbursement.
(iii) Unless appealed, a provider shall refund Medicaid within 30 days of written notification.
(e) When the department notifies a provider that the provider shall consolidate a readmission into a single episode of care payment, the provider shall:
(i) cancel the separate claims;
(ii) submit a consolidated claim reflecting the combined episode; and
(iii) comply with timelines and billing instructions issued by the department.
(11) The program shall conduct utilization review procedures for the Utah State Hospital (USH) in accordance with 42 CFR 456, Subpart D to ensure that Medicaid funds are expended appropriately and services to Medicaid members at USH are necessary and of high quality.
(12) The program shall implement policies that apply to inpatient psychiatric care and inpatient rehabilitation services.
(a) The program shall evaluate each readmission to an inpatient psychiatric or rehabilitation facility for clinical relatedness and preventability, as described in Subsection (5).
(b) The program shall apply a single episode care of payment for any determination of a preventable readmission or planned readmission within these specialized settings, and the determination is subject to the documentation standards outlined in the Utah Medicaid Hospital Services Provider Manual.

**R414-2A-10. Cost Sharing.**
(1) A Medicaid member is responsible for cost sharing as established in the Utah Medicaid State Plan and Rule R414-1.
(2) For readmissions consolidated into a single episode of care payment under Subsection R414-2A-9(6)(c), the Medicaid member may only be responsible for the cost sharing requirements associated with the initial admission.
(3) A provider may not collect additional copayment from a Medicaid member for a readmission that the department

determines to be a preventable readmission or a planned readmission.

**R414-2A-11. Reimbursement.**

(1) The department shall reimburse a provider for inpatient hospital services in accordance with Attachment 4.19-A of the Utah Medicaid State Plan.

(2) For the purposes of determining a hospital length of stay, the day of admission is counted as a full day, and the day of discharge is not counted.

(3) The department shall provide a single episode of care payment for a readmission determined to be a preventable readmission or planned readmission, as defined in Section R414-2A-2.

(a) Any day between the initial discharge and the readmission is considered a non-covered day.

(b) Each non-covered day between a discharge and a readmission is not eligible for separate reimbursement.

(c) The department may not provide separate reimbursement for any portion of an episode that is a preventable readmission or planned readmission.

(4) The department may not reimburse for a non-covered day, as defined in Section R414-2A-2, including any day lacking medical necessity or custodial care or used for patient convenience.

(5) The department shall reimburse a 30-day readmission as a separate claim if:

(a) the readmission is determined to be a non-preventable readmission;

(b) the diagnosis falls under a specific exclusion category listed in Subsection R414-2A-9(6)(d) and published in the Utah Medicaid Hospital Services Provider Manual; or

(c) the department determines that separate reimbursement is more cost effective to the department than a single episode of care payment.

(6) If a readmission involves a transfer between a DRG reimbursed unit and a non-DRG specialized unit within the same hospital, the department shall determine the primary reimbursement methodology for the combined episode.

(7) Requirements for claim submission, reporting of a non-covered day, and other operational billing procedures are maintained in the Utah Medicaid Hospital Services Provider Manual.

**KEY: Medicaid**
**Date of Last Change: [~~November 10, 2023~~]2026**
**Notice of Continuation: September 14, 2022**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108; 26B-3-110**

**State of Utah**
**Administrative Rule Analysis**
Revised May 2026

| NOTICE OF FIVE-YEAR REVIEW AND STATEMENT OF CONTINUATION | | |
|---|---|---|
| **Rule number:** | **R414-10** | **Filing ID: OFFICE USE ONLY** |

| | |
|---|---|
| **Effective date:** | **OFFICE USE ONLY** |

**1. Agency Information**

| | |
|---|---|
| **Title catchline:** | Health and Human Services, Integrated Healthcare |
| **Building:** | Cannon Health Building |
| **Street address:** | 288 N. 1460 W. |
| **City, state:** | Salt Lake City, Utah |
| **Mailing address:** | 288 N. 1460 W. |
| **City, state and zip:** | Salt Lake City, UT 84114 |

**2. Contact Persons**

| **Name:** | **Phone:** | **Email:** |
|---|---|---|
| Craig Devashrayee | 801-538-6641 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |

**Please address questions regarding information on this notice to the persons listed above.**

**3. General Information**

| **A. Rule catchline:** |
|---|
| R414-10. Physician Services. |

| **B. Statutory provisions that authorize or require this rule and an explanation of those particular statutory provisions:** | |
|---|---|
| Section 26B-1-213 | Section 26B-1-213 authorizes the Department of Health and Human Services (department) to adopt rules as necessary to carry out the provisions of Title 26B, Utah Health and Human Services Code, including Medicaid program implementation. |
| Section 26B-3-108 | Section 26B-3-108 requires the department to implement the Medicaid program through administrative rules. |

| **C. 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:** |
|---|
| No comments have been received since the last five-year review of this rule. |
| **D. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:** |
| Continuation of this rule is necessary because it provides a scope of physician services to meet Medicaid member needs, specifies member eligibility, and set forth requirements for program access.<br><br>As there were no comments in opposition to this rule, the department did not respond to any such comments. |

**4. Agency Authorization Information**

| **To the agency:** Information requested on this form is required by Section 63G-3-305. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin*. | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Commissioner | **Date:** | 10/11/2026 |
| **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 and Human Services, Integrated Healthcare.**
**R414-10. Physician Services.**
**R414-10-1. Introduction and Authority.**

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

(2) Physician services are a mandatory Medicaid program authorized by Section 1901 of the Social Security Act, Subsections 1861(q)(r) and 1905(a)(5)(6) of the Social Security Act, and Sections 26B-1-213 and 26B-3-108.

**R414-10-2. Definitions.**

In addition to the definitions in Rule R414-1, the following definitions apply to this rule.

(1) "Assistant to surgery" means a physician or non-physician practitioner who actively assists the physician in charge of a case in performing a surgical procedure.

(2) "Family planning" means diagnosis, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy.

(3) "Global surgical procedures" means preoperative office visits and preparation, the operation itself, local infiltration, topical or regional anesthesia when used, and normal follow-up care.

(4) "Non-physician practitioner" means covered member healthcare providers who practice either in collaboration with or under the supervision of a physician, including physician assistants and nurse practitioners.

(5) "Nurse practitioner" means an individual who performs professional services within the scope of licensing of a nurse practitioner pursuant to Title 58, Chapter 31b, Nurse Practice Act.

(6) "Physician services", whether furnished in the office, the member's home, a hospital, a skilled nursing facility, or elsewhere, means services performed by a Medicaid provider that meet the following standards:

(a) services are performed within the scope of the physician's license as defined in Title 58, Occupations and Professions;

(b) services are performed by a doctor of medicine or osteopathy, a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, a chiropractor, or;

(c) services include medical care, or any other type of remedial care furnished by licensed practitioners.

(7) "Physician assistant" means:

(a) an individual who performs professional services within the scope of licensing in accordance with Title 58, Chapter 70a, Utah Physician Assistant Act.

(8) "Services" means the types of medical assistance specified in Subsection 1905(a) of the Social Security Act and interpreted in 42 CFR 440.

**R414-10-3. Member Eligibility Requirements.**

Physician services are available to categorically and medically needy eligible individuals.

**R414-10-4. Program Access Requirements.**

(1) An eligible Medicaid member may obtain physician services from any Utah Medicaid provider.

(2) An individual who does not meet United States residency requirements may only receive emergency services, including emergency labor and delivery, to treat an emergency medical condition, as stated in Section R414-1-7.

(a) Medicaid does not cover prenatal and post-partum services for undocumented immigrants.

**R414-10-5. Service Coverage and Limitations.**

(1) This section contains general information on coverage and limitations for physician services.

(a) Physician services may be provided only within the parameters of accepted medical practice and are subject to limitations and exclusions established by the department based on appropriateness, medical necessity, and utilization control considerations.

(b) Medicaid covers cosmetic or reconstructive procedures pursuant to Section R414-1-29.

(c) Medicaid covers experimental or medically unproven physician services pursuant to Rule R414-1A.

(d) Program limitations and non-covered services are maintained in the Coverage and Reimbursement Code Lookup and updated by notification through the Medicaid Information Bulletin. Medicaid may not cover any:

(i) medically unnecessary or unreasonable service;

(ii) paternity test;

(iii) service claimed fraudulently;

(iv) service, elective in nature, based on patient request or individual preference rather than medical necessity;

(v) service provided during a period in which an individual is ineligible for Medicaid;

(vi) service provided without required prior authorization;

(vii) service rejected or disallowed by Medicare when the rejection is based on any reason listed in this section;

(viii) service that fails to meet existing standards of professional practice;

(ix) service that represents abuse or overuse;

(x) related service, supply, or institutional cost during a post-operative recovery period, if the service or procedure is

not covered for any reason specified in this section or due to policy exclusion; and

(xi)(A) service for which third party payers are primarily responsible for coverage, such as Medicare, private health insurance, and liability insurance, pursuant to Rule R527-936.

(B) Medicaid may make a partial payment up to the Medicaid maximum if a third party does not reach the payment limit.

(e) Medicaid covers treatment for alcoholism or drug dependency in an inpatient setting pursuant to Subsection R414-2A-7(1).

(2) Medicaid may not cover the following family planning services:

(a) any surgical procedure for the reversal of previous elective sterilization on both males and females; or

(b) surrogate motherhood, including any service, test, and related charge.

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

(4) Medicaid may not cover any anesthesia standby service.

(5) Medicaid may cover the following surgical global services and procedures:

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

(b) the operation;

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

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

(6) The following criteria apply to global services.

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

(b)(i) Only the consulting physician may bill for consultation services when consultation and no other service is provided.

(ii) When a consulting physician admits and follows a patient, independently or concurrently with the primary physician, the consulting physician may only use admission codes and subsequent care codes.

(c)(i) Office visits after hospitalization that relate to the same diagnosis are part of the global service.

(ii) The only exception to either inpatient or office service is for a service related to a complication, exacerbation, or recurrence of another disease or problem requiring an additional or separate service.

(d) Any complication, exacerbation, recurrence, or the presence of another disease or injury, which requires a service concurrent with the initial surgical procedure during the listed period of normal follow-up care, may warrant additional charges only when the record shows extensive documentation and justification of the additional service.

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

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

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

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

(iii) when diagnostic procedures are not part of the basic surgical procedure.

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

(8) Limited abortion services shall meet the requirements of Rule R414-1B.

(9) Sterilization and hysterectomy procedures shall meet the requirements of 42 CFR 441 Subpart F (2024).

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

(11) Medicaid may cover the following psychiatric services as a medical benefit:

(a) a mental health service that targets the diagnosis or treatment of developmental disability or organic disorder;

(b) a physician-ordered psychiatric service for a patient hospitalized in a non-psychiatric unit of a hospital; or

(c) a psychosocial evaluation requested before organ transplant, a psychiatric evaluation before another medical service or surgical procedure, and an evaluation for an individual with a condition that requires chronic pain management services.

(12) Medicaid may cover the following pain management services:

(a) pain management for delivery and acute post-operative pain; and

(b) treatment for chronic pain.

(13) Medicaid may cover a prescription medication subject to the requirements of Rule R414-60.

**KEY: Medicaid**
**Date of Last Change: November 13, 2025**
**Notice of Continuation: October 19, 2021**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108; 26B-3-215; 26B-3-216**

**State of Utah**
**Administrative Rule Analysis**
Revised May 2026

| NOTICE OF SUBSTANTIVE CHANGE | |
|---|---|
| **TYPE OF FILING:** Amendment | **Filing ID: OFFICE USE ONLY** |
| **Rule or section number:** | **R414-60** |
| **Date of previous publication (only for CPRs):** | |

**1. Agency Information**

| | |
|---|---|
| **Title catchline:** | Health and Human Services, Integrated Healthcare |
| **Building:** | Cannon Health Building |
| **Street address:** | 288 N. 1460 W. |
| **City, state:** | Salt Lake City, UT |
| **Mailing address:** | PO Box 143325 |
| **City, state and zip:** | Salt Lake City, UT 84114-3325 |

**2. Contact Persons**

| Name: | Phone: | Email: |
|---|---|---|
| Craig Devashrayee | 801-915-4493 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |

**Please address questions regarding information on this notice to the persons listed above.**

**3. General Information**

**A. Rule or section catchline:**

R414-60. Medicaid Policy for Pharmacy Program.

**B. Purpose of the new rule or reason for the change:**

Based on discussions within the Division of Integrated Healthcare, the purpose of this amendment is to update and clarify, by rule, current policy for the Medicaid Pharmacy Program.

**C. Summary of the new rule or change:**

This amendment updates and clarifies definitions, drug coverage, coverage limitations, reimbursement, and policies for new drugs, over-the-counter drugs, compounds, and provider-administered drugs.

**4. Legislative Action Information**

| | |
|---|---|
| **A. Are any changes in this filing because of state legislative action?** | Changes are not because of legislative action. |
| **B. If yes, any bill number and session:** | |

**5. Fiscal Information**

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

**A. State budget:**

The department does not expect a fiscal impact to the state budget as the department already implements current policy through the Medicaid State Plan and the Pharmacy Services Utah Medicaid Provider Manual. Procedures for implementing these provisions are already in place, and this filing does not add to, modify, or remove any associated processes.

**B. Local governments:**

The department does not expect a fiscal impact on local governments as they neither fund nor provide pharmacy services under the Medicaid program.

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

The department does not expect a fiscal impact on small businesses as the department already implements current policy through the Medicaid State Plan and the Pharmacy Services Utah Medicaid Provider Manual. Procedures for implementing these provisions are already in place, and this filing does not add to, modify, or remove any associated processes.

| |
|---|
| **D. Non-small businesses** ("non-small business" means a business employing 50 or more persons)**:** |
| The department does not expect a fiscal impact on non-small businesses as the department already implements current policy through the Medicaid State Plan and the Pharmacy Services Utah Medicaid Provider Manual. Procedures for implementing these provisions are already in place, and this filing does not add to, modify, or remove any associated processes. |
| **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***)**:** |
| Medicaid members and entities outside of government or business are not expected to see a fiscal impact as the department already implements current policy through the Medicaid State Plan and the Pharmacy Services Utah Medicaid Provider Manual. Procedures for implementing these provisions are already in place, and this filing does not add to, modify, or remove any associated processes. |
| **F. Compliance costs for affected persons:** |
| There are no expected compliance costs for affected persons, including the state, small businesses, non-small businesses, and a Medicaid member or single entity outside of government or business, as the department already implements current policy through the Medicaid State Plan and the Pharmacy Services Utah Medicaid Provider Manual. Procedures for implementing these provisions are already in place, and this filing does not add to, modify, or remove any associated processes. |

**6. Regulatory Impact Summary Table**

Enter the cost or savings in the relevant cell. If there is no cost or savings, enter, "$0." If a cost or savings is inestimable, enter, "inestimable."

| **Fiscal Cost** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
|---|---|---|---|---|---|
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Cost** | **$** | **$** | **$** | **$** | **$** |
| **Fiscal Benefits** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Benefits** | $0 | $0 | $0 | $0 | $0 |
| **Net Fiscal Benefits** | $0 | $0 | $0 | $0 | $0 |

**7. Regulatory Impact Analysis Approval**

The Commissioner of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

**8. Family Impact Information**

| | |
|---|---|
| **A. The agency has considered this rule's impact on family health, stability, and formation:** | ☒ |

| **B. Summary of reasonable alternatives or modifications:** |
|---|
| |

**9. Citation Information**

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

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

**10. Incorporation by Reference Information**

| **Incorporation by Reference** (if this rule incorporates more than two items by reference, please include additional tables)**:** | |
|---|---|
| **A. This rule adds or updates the following title of material incorporated by reference** (a copy of the material 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 or updates the following title of material incorporated by reference** (a copy of the material 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** | |

**11. Public Notice Information**

| **The public may submit written or oral comments to the agency identified in box 1.** | |
|---|---|
| **A. Comments will be accepted until:** | |

| **B. A public hearing (optional) will be held** (The public may request a hearing by submitting a written request to the agency, as outlined in Section 63G-3-302 and Rule R15-1.)**:** | | |
|---|---|---|
| **Date:** | **Time** (hh:mm AM/PM)**:** | **Place** (physical address or URL)**:** |
| | | |

**To the agency:** If more than one hearing is planned to take place, continue to add rows.

**12. Effective Date Information**

| **This rule change MAY become effective on:** (NOTE: This is the date the agency anticipates making the filing effective. It is NOT the effective date) | |
|---|---|

**13. Agency Authorization Information**

| **To the agency**: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date. | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Commissioner | **Date:** | 09/28/2026 |

**R414. Health and Human Services, Integrated Healthcare.**
**R414-60. Medicaid Policy for Pharmacy Program.**
**R414-60-2. Definitions.**

(1) "Covered outpatient drug" means a drug that meets the Centers for Medicare and Medicaid Services (CMS) covered outpatient drug definition as outlined in 42 CFR 447.502 (2026).[ ~~The following provisions also apply:~~

~~(a) requires a prescription for dispensing;~~

~~(b) has a national drug code number;~~

~~(c) is eligible for federal medical assistance percentages funds;~~

~~(d) has been approved by the Food and Drug Administration; and~~

~~(e) is listed in the nationally recognized drug pricing index under contract with the Department.~~]

(2) "Full-benefit dual eligible member" means an individual who has Medicare and Medicaid benefits.

(3) "Provider-administered drug" means an outpatient drug, other than a vaccine, that is administered by a health care provider in a physician's office or other outpatient clinical setting.

(4) "Rural pharmacy" means a pharmacy located in the state and is not located in Weber County, Davis County, Utah County, or Salt Lake County.

([4]5) "Urban pharmacy" means a pharmacy located in Weber County, Davis County, Utah County, Salt Lake County, or in another state.

([~~5~~]6) "Usual and customary charge" means the lowest amount a pharmacy charges the general public for a covered outpatient drug, which reflects advertised savings, discounts, special promotions, or any other program available to the general public.

([~~6~~]7) "Wholesale acquisition cost" means the list price paid by the wholesaler, distributor, and other direct accounts for drugs purchased from the wholesaler's supply.

([~~7~~]8) "Medically accepted indication" means, in accordance with 42 U.S.C. 1396r-8 (k)(6), [~~is~~ ]any use:

(a) approved by the Federal Food,[~~and~~] Drug, [~~Administration (FDA)~~]and Cosmetic Act, 21 U.S.C. 301 et seq.; or[~~- a use~~]

(b) supported by [~~on~~]at least one citation in the[~~of the following compendia~~]:

([~~a~~]i) American Hospital Formulary Service Drug Information;

(ii) American Medical Association Drug Evaluations;

(iii) DRUGDEX Information System; or

([~~b~~]iv) United State Pharmacopeia-Drug Information.[~~; or~~

~~(c) the DRUGDEX Information System.~~]

**R414-60-4. Program Coverage.**

(1) [~~C~~]Each covered outpatient drug[~~s~~] eligible for federal medical assistance percentages funds [~~are~~]is included in the pharmacy benefit; however, a covered outpatient drug[~~s~~] may be subject to limitations and restrictions.

(2) In accordance with Subsection 58-17b-606(4), if a multi-source A-rated legend drug is available in the generic form, Medicaid reimburses only for the generic form of the drug unless:

(a) reimbursing for the non-generic brand-name legend drug will result in a financial benefit to the state;

(b) the treating physician demonstrates a medical necessity for dispensing the non-generic, brand-name legend drug; or

(c) the generic form of the drug is unavailable in the marketplace as [~~defined~~]described in the Utah Medicaid Pharmacy Services Provider Manual.

(3) 42 U.S.C 1396b(i)(23) requires Medicaid prescriptions not executed electronically to be written on tamper-resistant prescription forms.[~~- as follows:~~]

(a) A prescriber shall write any Medicaid prescription not executed electronically on a tamper-resistant prescription form[~~s~~] [~~must~~]that includes[~~- each of the following~~]:

(i) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(ii) one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

(iii) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(b)(i) Documentation by the pharmacy of verbal confirmation of a prescription that the prescriber or prescriber's agent has not written on a tamper-resistant prescription form[~~- by the prescriber or the prescriber's agent~~] satisfies the tamper-resistant requirement.

(ii) The pharmacy shall include in [~~D~~]documentation of [~~the~~]a verbal confirmation [~~must include~~] the date, time, and name of the individual who verified the validity of the prescription.

(c)(i) A pharmacy [~~must~~]shall maintain documentation that:

(A) a Medicaid member or authorized representative has received a prescription for a covered outpatient drug; and[~~. The documentation must~~]

(B) clearly identif[~~y~~]ies the covered outpatient drug and the date [~~it~~]the drug was received.

(ii) The Division of Integrated Healthcare (division) shall waive the proof of delivery requirement for Non-Controlled and Controlled Schedule III to V[~~Schedule 2~~] prescriptions.

(iii) In accordance with Subsection [~~R414-60-4~~](3)(c)(i), the proof of delivery requirement remains for Controlled Schedule [~~2~~]II (CII) medications [~~that includes~~]requiring a signature or other documentation. The pharmacy shall document member receipt as stated in Subsection [~~R414-60-4~~](3)(c)(i).

(d) If there is a [~~C~~]claim[~~s~~] for a covered outpatient drug[~~s~~] not dispensed to a Medicaid member or the member's authorized representative within 14 days[~~- must be reversed and~~]:

(i) the division shall reverse the claim; and

(ii) the pharmacy shall return any payment from Medicaid [~~must be returned~~].

**R414-60-5. Limitations.**

(1) Medicaid may place limitations on drugs in accordance with 42 U.S.C. 1396r-8 or in consultation with the Drug Utilization Review Board. Medicaid includes these limitations in the Pharmacy Services Provider Manual and attachments. These limitations are incorporated by reference in Section R414-1-5 and may include:

(a) quantity limits or cumulative limits for a drug or drug class for a specified period;

(b) therapeutic duplication limits, which may be placed on drugs within the same or similar therapeutic categories;

(c) step therapy, including documentation of therapeutic failure with one drug before another drug may be used; or

(d) prior authorization.

(2) A pharmacy may dispense a covered outpatient drug that requires prior authorization for up to a 72-hour supply without obtaining prior authorization during a medical emergency.

(3) A drug listed as non-preferred on the Preferred Drug List [~~(PDL)~~ ]may require prior authorization [~~as authorized by~~]in accordance with Section 26B-3-105.

(4) A drug may be restricted and is reimbursable only if dispensed by an individual pharmacy or pharmacies.

(5) Medicaid does not cover any drug not eligible for federal medical assistance percentages funds.

(6) Medicaid does not cover any outpatient drug included in the Medicare Prescription Drug Benefit-Part D for any full-benefit dual eligible member.

(7) Medicaid does not cover any drug provided to a member during an inpatient hospital stay, neither as an outpatient pharmacy benefit nor separately payable from the Medicaid payment for the inpatient hospital services.

(8) Medicaid covers prescription cough and cold preparations meeting the definition of a covered outpatient drug.

(9) Medicaid pays for no more than a one-month supply of a covered outpatient drug for each dispensing, except that:

(a) Medicaid may cover a medication on the Utah Medicaid Three-Month Supply [~~Medication~~]Required List, attachment to the Pharmacy Services Provider Manual, for up to a three-month supply for each dispensing; and

(b) Medicaid may cover prenatal vitamins for a pregnant woman, multiple vitamins with or without fluoride for a child who is zero through five years of age, and fluoride supplements through 16 years of age.[~~ for up to a three-month supply for each dispensing;~~

~~(c) Medicaid may cover contraceptives for up to a three-month supply for each dispensing; and~~

~~(d) Medicaid may cover a long-acting injectable antipsychotic drug in accordance with Section R414-60-12 for up to a three-month supply for each dispensing.~~]

(10)(a) Medicaid pays for a prescription refill for non-controlled substances only if 80% of the previous prescription has been exhausted[~~, except for a controlled substance~~].

(b) Medicaid pays for a prescription refill for a controlled substance after 85% of the previous prescription has been exhausted.

(11) Medicaid covers treatments for fertility preservation and in vitro fertilization, only as described in the Utah Medicaid Provider Manual, for individuals who receive medical treatment that includes surgery, radiation, chemotherapy, or another medical intervention that poses the risk of sterility or leads to iatrogenic infertility.

(12) Medicaid does not cover:

(a) a drug for weight loss, except for specific indications;

(b) a drug for the treatment of sexual dysfunction;

(c) a drug for cosmetic purposes;

(d) vitamins[~~;~~], except [~~for~~]as listed in Subsection (9)(b)[~~ prenatal vitamins for a pregnant woman, vitamin drops for a child who is zero through five years of age, and fluoride supplements~~];

(e) an over-the-counter (OTC) drug [~~(OTC) ~~]not included on the Utah Medicaid [~~PDL~~]Preferred Drug List and Resources document[~~ attachment to the Pharmacy Services Provider Manual~~];

(f) a drug for which the manufacturer requires, as a condition of sale, that associated tests and monitoring services are purchased exclusively from the manufacturer or [~~it~~]the manufacturer's designee;

(g) a drug given by a hospital to a patient at discharge;

(h) breast milk, breast milk substitutes, baby food, or medical foods[~~, P~~], though prescription metabolic products for congenital errors of metabolism are covered through the [~~D~~]durable [~~M~~]medical [~~E~~]equipment benefit; and

(i) a drug available only through a single-source distribution program, unless the distributor is enrolled with Medicaid as a pharmacy provider.

(13) A claim for opioids used for the treatment of non-cancer pain is subject to the following limitations or restrictions set forth by the division[~~Division of Integrated Healthcare (DIH)~~]:

(a) initial fill limits;

(b) monthly limits;

(c) quantity limits;

(d) additional limits for a child or pregnant woman;

(e) daily morphine milligram equivalents (MME)[~~ and cumulative morphine equivalents daily (MED)~~] limits;

(f) concurrent use of opioids with high-risk drugs as defined by [~~DIH~~]the division; or

(g) concurrent use of opioid medications in a Medicaid member[~~s~~] who also receives medication-assisted treatment (MAT) for opioid use disorder.

(14) An antipsychotic medication prescribed to a Medicaid member who is 19 years of age or younger is limited as follows:

(a) no use of multiple antipsychotic drugs;

(b) no off-label use;

(c) no use outside established age guidelines; and

(d) no doses higher than FDA recommendations.

[~~(15) An exception may be granted as appropriate through the prior authorization process.~~

] (1[~~6~~]5) An attention[~~-~~] deficit[~~/~~] hyperactivity disorder (ADHD) stimulant medication is subject to the following limitations or restrictions set forth by [~~DIH~~]the division for Medicaid members:

(a) age limits;

[~~(b) monthly limits;~~

~~(c) quantity limits;~~]

([~~d~~]b) cross-class limitations for concurrent use of an amphetamine class with methylphenidate class in children less than 18 years of age; or

([~~e~~]c) the use of no more than two ADHD stimulants by a member of any age.

[~~(17) Medicaid evaluates exceptions to ADHD stimulant policy for medical necessity on a case-by-case basis.~~
] (1[~~8~~]6) The [~~"~~]dispense as written[~~"~~] (DAW-1) code may override [~~the non-preferred~~]a prior authorization requirement for selected non-preferred [~~antipsychotic~~]medications if the prescriber writes "dispense as written" on a prescription.

(17) The department may grant an exception as appropriate through the prior authorization process.

**R414-60-7. Reimbursement.**

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

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

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

(4) A pharmacy that participates in the [~~f~~]Federal [~~s~~]Supply [~~s~~]Schedule (FSS) and uses medications obtained through the schedule to bill Medicaid [~~must~~]shall submit the FFS acquisition cost of the medication on the claim unless the claim is reimbursed as a bundled charge or all-inclusive rate.

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

(6)[~~(a)~~] Dispensing fees are outlined in Attachment 4.19-B of the Medicaid State Plan.

([~~b~~]a) Medicaid pays the lesser of:

(i) the assigned dispensing fee; or

(ii) the submitted dispensing fee.

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

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

[~~(8)(a)~~](7)(a) Medicaid may only pay a dispensing and administration fee to a provider who administers a vaccine to a Medicaid member who is 18 years of age or younger but may not reimburse a provider for the vaccine product.[~~Medicaid pays a provider that immunizes a Medicaid member who is 19 years of age or older for the cost of the immunization plus a dispensing fee.~~]

(b) A Medicaid member who is 18 years of age or younger shall obtain any vaccine through the Vaccines for Children Program.

[~~(b) Medicaid pays the lesser of:~~

~~(i) the allowed charges; or~~

~~(ii) the submitted charges.~~

~~(9) A provider that immunizes a Medicaid member who is 18 years of age or younger may only be eligible for a dispensing fee with no reimbursement for the immunization. Immunizations for Medicaid members who are 18 years of age or younger must be obtained through the Vaccines for Children program.~~
] ([~~10~~]8) Diabetic supplies listed on the Utah Medicaid [~~PDL~~]Preferred Drug List are reimbursed at the lesser of:

(a) the wholesale acquisition cost with no dispensing fee; or

(b) [~~or~~]the billed charges.

([~~11~~]9) Pursuant to Section 58-17b-805, a dispensing medical practitioner may prescribe and dispense medication directly to a patient if providing outpatient cancer therapy. Details of reimbursement are found on the Medicaid website at http://health.utah.gov/stplan/lookup/CoverageLookup.php.

**R414-60-8. Mandatory Patient Counseling.**

(1) A Medicaid member[~~s,~~] or [~~their~~]authorized representative[~~s,~~] [~~must~~]shall receive counseling that fulfills the requirements of 42 U.S.C. 1396r-8 each time a covered outpatient medication is dispensed.

(2) If a Medicaid member or authorized representative refuses the offer of counseling, a pharmacy facility is not required to provide that Medicaid member or authorized representative with counseling, in accordance with Section R156-17b-610[~~does not require counseling if a Medicaid member or their representative refuses the offer of counseling~~].

(a) Only a pharmacist, pharmacy intern, or designated medical practitioner may provide [~~oral~~]verbal counseling [~~to a member or member's representative and~~]or answer questions concerning prescription drugs.

(3) The pharmacy facility shall document the offer of counseling [~~must be documented~~ ]and [~~producible~~]make that documentation available to the department upon request.

(4) [W]A pharmacy facility shall deliver any written information on a prescription order [~~delivered~~ ]to a Medicaid member and shall be [~~in the~~ ]format that information [~~of~~]as a patient information leaflet[~~s~~].

**R414-60-9. New Drug Products.**

(1) [~~A~~]The Drug Utilization Review Board may review a new drug product, including a new size or strength of an existing approved product, [~~may be reviewed by the DUR Board~~ ]to determine whether the drug should be subject to restrictions or limitations.

(2) [~~N~~]A new drug[~~s~~] may be withheld from coverage for no more than 12 weeks while the Drug Utilization Review Board evaluates potential restrictions or limitations[~~are being evaluated~~].

**R414-60-10. Over-the-Counter Drugs.**

(1) Medicaid covers an OTC drug[~~s~~] if the drug is listed on the Preferred Drug List and Pharmacy Coverage Resources document [~~Utah Medicaid PDL and Resources attachment to the Pharmacy Services Provider Manual, incorporated by reference in Section R414-1-5~~].

(2) For a Medicaid member who resides in a nursing facility, Medicaid does not cover an OTC drug under the outpatient pharmacy benefit. Reimbursement for an OTC drug is included in the nursing facility daily rate and not reimbursed separately through the pharmacy program[~~For a Medicaid member who resides in a nursing home, OTC drugs on the approved list are not a benefit through the outpatient pharmacy program. The nursing home rate of reimbursement includes payment for OTC drugs~~].

**R414-60-11. Compounds.**

(1) A compounded drug consists of two or more ingredients. Medicaid may only reimburse a pharmacy[~~ies~~] for [~~the~~]an ingredient that:

(a) meets the definition of a covered outpatient drug[~~,~~]; and

(b) is not [~~except for those listed~~]described [~~as non-covered drugs~~ ]in Section R414-60-5.

(2) Qualified personnel shall prepare any compounded non-sterile prescription in an environment that complies with the requirements of the United States Pharmacopeia-National Formulary Chapter <795>.[~~Compounded non-sterile prescriptions must be prepared by personnel and in settings as defined in the United States Pharmacopeia and National Formulary Chapter <795>.~~]

(3)(a) Qualified personnel shall prepare any compounded sterile prescription in a facility that complies with the requirements of the United States Pharmacopeia-National Formulary Chapter <797>.

(b) A facility shall perform appropriate testing to ensure the final product meets applicable sterility, potency, and purity standards.[~~Compounded sterile prescriptions must be prepared by personnel and in settings that have certified they adhere to the United States Pharmacopeia/National Formulary chapter <797> standard, and test the final product for sterility, potency, and purity.~~]

(4) Medicaid does not cover bulk powders for compounded prescriptions.

**R414-60-12. Provider-Administered Drugs|~~Long-Acting Injectable Antipsychotic Drugs and Drugs for the Treatment of Opioid Use Disorders~~|.**

(1) [~~A provider-administered drug is an outpatient drug, other than a vaccine, that is administered by a health care provider in a physician's office or other outpatient clinical setting.~~

~~(2)~~ ]Medicaid may only reimburse for a provider-administered drug if the drug qualifies as a covered outpatient drug in accordance with 42 U.S.C 1396r-8.

([~~3~~]2) A pharmacy facility shall dispense select provider-administered or provider-observed drugs directly to the prescribing provider or the provider's authorized staff, as identified on the Preferred Drug List.[~~Selected provider-administered or provider-observed drugs must be dispensed directly to the provider or provider's staff. These include the following:~~

~~(a) long-acting injectable antipsychotics; and~~

~~(b) long-acting injectable drugs for the treatment of opioid use disorders.~~]

**KEY: Medicaid**
**Date of Last Change: [~~January 20,~~ ]2026**
**Notice of Continuation: March 11, 2022**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108**

**State of Utah**
**Administrative Rule Analysis**
Revised May 2026

| NOTICE OF SUBSTANTIVE CHANGE | |
|---|---|
| **TYPE OF FILING:** Amendment | **Filing ID: OFFICE USE ONLY** |
| **Rule or section number:** | **R414-302-8** |
| **Date of previous publication (only for CPRs):** | |

**1. Agency Information**

| | |
|---|---|
| **Title catchline:** | Health and Human Services, Integrated Healthcare |
| **Building:** | Cannon Health Building |
| **Street address:** | 288 N. 1460 W. |
| **City, state:** | Salt Lake City, UT |
| **Mailing address:** | PO Box 143325 |
| **City, state and zip:** | Salt Lake City, UT 84114-3325 |

**2. Contact Persons**

| Name: | Phone: | Email: |
|---|---|---|
| Craig Devashrayee | 801-915-4493 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |

**Please address questions regarding information on this notice to the persons listed above.**

**3. General Information**

**A. Rule or section catchline:**

R414-302-8. Application for Other Possible Benefits.

**B. Purpose of the new rule or reason for the change:**

This filing implements a change in policy that no longer requires an individual to apply for other financial benefits before applying for Medicaid.

**C. Summary of the new rule or change:**

This filing implements a change in policy that no longer requires an individual to apply for other financial benefits before applying for Medicaid. It also removes provisions for modified adjustment gross income and Veterans Administration benefits that no longer apply to this rule.

**4. Legislative Action Information**

| | |
|---|---|
| **A. Are any changes in this filing because of state legislative action?** | Changes are not because of legislative action. |
| **B. If yes, any bill number and session:** | |

**5. Fiscal Information**

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

**A. State budget:**

The department estimates a total cost of about $262,747 based on an increase to the General Fund, its federal match, and an increase to the fund for Medicaid expansion in accordance with the Affordable Care Act. There is no estimated savings to the state budget.

**B. Local governments:**

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

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

The department estimates an increase in revenue for small businesses based on an increase in eligibility and coverage for Medicaid members. There is, however, no available data to estimate the number of individuals who will become eligible for Medicaid with the removal of the requirement to apply for other financial benefits, and it is impossible to know how many of those individuals will seek services from small businesses. Therefore, this anticipated increase in revenue is considered

inestimable. There is no estimated cost to small businesses.

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

The department estimates an increase in revenue for non-small businesses based on an increase in eligibility and coverage for Medicaid members. There is, however, no available data to estimate the number of individuals who will become eligible for Medicaid with the removal of the requirement to apply for other financial benefits, and it is impossible to know how many of those individuals will seek services from non-small businesses. Therefore, this anticipated increase in revenue is considered inestimable. There is no estimated cost to non-small businesses.

**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***)**:**

The department does not expect this change to have a fiscal impact on entities outside of businesses or government because it only affects individuals who may qualify for services under the Medicaid program and providers of Medicaid services. While this filing may increase the number of individuals who become eligible for Medicaid services, there is no available data to estimate the number of individuals who will become eligible for Medicaid with the removal of the requirement to apply for other financial benefits, and that number is inestimable.

**F. Compliance costs for affected persons:**

There are no anticipated compliance costs for small businesses, non-small businesses, or other persons, including individuals who may qualify for Medicaid services, as this change is expected to only result in out-of-pocket savings for an individual who qualifies for Medicaid and an increase in revenue for a provider of Medicaid services.

While the state is estimated to see a total cost of $262,747 based on an increase to the General Fund, its federal match, and an increase to the fund for Medicaid expansion in accordance with the Affordable Care Act. However, because there is no available data to estimate the number of individuals who will become eligible for Medicaid with the removal of the requirement to apply for other financial benefits, the amount of an individualized compliance cost is inestimable.

**6. Regulatory Impact Summary Table**

Enter the cost or savings in the relevant cell. If there is no cost or savings, enter, "$0." If a cost or savings is inestimable, enter, "inestimable."

| **Fiscal Cost** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
|---|---|---|---|---|---|
| State Budget | $262,747 | $262,747 | $262,747 | $262,747 | $262,747 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Cost** | **$262,747** | **$262,747** | **$262,747** | **$262,747** | **$262,747** |
| **Fiscal Benefits** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Benefits** | $0 | $0 | $0 | $0 | $0 |
| **Net Fiscal Benefits** | **($262,747)** | **($262,747)** | **($262,747)** | **($262,747)** | **($262,747)** |

**7. Regulatory Impact Analysis Approval**

The Commissioner of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

**8. Family Impact Information**

| **A. The agency has considered this rule's impact on family health, stability, and formation:** | ☒ |
|---|---|

**B. Summary of reasonable alternatives or modifications:**

| |
|---|
| |

**9. Citation Information**

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

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

**10. Incorporation by Reference Information**

| **Incorporation by Reference** (if this rule incorporates more than two items by reference, please include additional tables)**:** | |
|---|---|
| **A. This rule adds or updates the following title of material incorporated by reference** (a copy of the material 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 or updates the following title of material incorporated by reference** (a copy of the material 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** | |

**11. Public Notice Information**

| **The public may submit written or oral comments to the agency identified in box 1.** | |
|---|---|
| **A. Comments will be accepted until:** | |

| **B. A public hearing (optional) will be held** (The public may request a hearing by submitting a written request to the agency, as outlined in Section 63G-3-302 and Rule R15-1.)**:** | | |
|---|---|---|
| **Date:** | **Time** (hh:mm AM/PM)**:** | **Place** (physical address or URL)**:** |
| | | |

**To the agency:** If more than one hearing is planned to take place, continue to add rows.

**12. Effective Date Information**

| | |
|---|---|
| **This rule change MAY become effective on:**<br>(NOTE: This is the date the agency anticipates making the filing effective. It is NOT the effective date) | |

**13. Agency Authorization Information**

| **To the agency**: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date. | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Commissioner | **Date:** | 09/28/2026 |

**R414. Health and Human Services, Integrated Healthcare.**

**R414-302. Eligibility Requirements.**

**R414-302-8. Application for [~~Other Possible Benefits~~]Medicare Part B.**

[~~(1) The department implements 42 CFR 435.608, which requires applicants for and members of medical assistance to apply for and take reasonable steps to receive other possible benefits.~~

~~(2) The department may not require an applicant for or member of medical assistance to apply for an income benefit if the applicant's or member's income is not counted when determining eligibility for medical assistance for either that individual or any other household member.~~

~~(3)~~]([~~a~~]1) An individual who may be eligible for Medicare Part B benefits must apply for Medicare Part B and, if eligible, become enrolled in Medicare Part B to be eligible for Medicaid.

([~~b~~]2) The state pays the applicable monthly premium and cost-sharing expenses for Medicare Part B for an individual who is eligible for both Medicaid and Medicare Part B.[

~~(4) An individual whose eligibility is determined using non-Modified Adjusted Gross Income (MAGI) methodologies and who may be eligible for a Veterans Administration (VA) apportionment payment of benefits, as defined by the VA, must apply for those benefits.~~]

**KEY: state residency, citizenship, third-party liability, Medicaid**
**Date of Last Change: [~~January 22, 2024~~]2026**
**Notice of Continuation: January 6, 2023**
**Authorizing, and Implemented or Interpreted Law: [~~26B-3-108;~~ ]26B-1-213; 26B-3-108**

**State of Utah**
**Administrative Rule Analysis**
Revised May 2026

| NOTICE OF SUBSTANTIVE CHANGE | |
|---|---|
| **TYPE OF FILING:** New | **Filing ID: OFFICE USE ONLY** |
| **Rule or section number:** | **R414-340** |
| **Date of previous publication (only for CPRs):** | |

**1. Agency Information**

| | |
|---|---|
| **Title catchline:** | Health and Human Services, Integrated Healthcare |
| **Building:** | Cannon Health Building |
| **Street address:** | 288 N. 1460 W. |
| **City, state:** | Salt Lake City, UT |
| **Mailing address:** | PO Box 143325 |
| **City, state and zip:** | Salt Lake City, UT 84114-3325 |

**2. Contact Persons**

| Name: | Phone: | Email: |
|---|---|---|
| Craig Devashrayee | 801-915-4493 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |

**Please address questions regarding information on this notice to the persons listed above.**

**3. General Information**

**A. Rule or section catchline:**

R414-340. Health Care Transparency and Accountability.

**B. Purpose of the new rule or reason for the change:**

In accordance with HB 566, of the 2026 General Session, the purpose of this rule is to implement new rulemaking requirements from Sections 26B-3-1202 and 26B-3-1203 that address transparency within the Medicaid program in relation to payments, published reports, and data submitted by managed care plans.

**C. Summary of the new rule or change:**

This rule establishes procedures for the Division of Integrated Healthcare (division) to develop and maintain a Medicaid data dashboard with information furnished by managed care plans. It also sets forth obligations for risk contractors and subcontractors regarding dashboard data submissions, improper payment identification and remediation, and sanctions for noncompliance by risk contractors of related requirements.

**4. Legislative Action Information**

| | |
|---|---|
| **A. Are any changes in this filing because of state legislative action?** | Changes are because of legislative action. |
| **B. If yes, any bill number and session:** | HB 566 (2026 General Session) |

**5. Fiscal Information**

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

**A. State budget:**

This filing is not anticipated to create a fiscal impact to the state budget, as this filing implements statutory requirements from Sections 26B-3-1202 and 26B-3-1203, enacted through HB 566. Any fiscal impact to the state budget resulting from HB 566 can be found in the fiscal note for this bill at https://pf.utleg.gov/public-web/sessions/2026GS/fiscal-notes/HB0566S03.fn.pdf.

**B. Local governments:**

This filing is not anticipated to create a fiscal impact to local governments, as this filing implements statutory requirements from Sections 26B-3-1202 and 26B-3-1203, enacted through HB 566. Any fiscal impact to local governments resulting from HB 566 can be found in the fiscal note for this bill at https://pf.utleg.gov/public-web/sessions/2026GS/fiscal-notes/HB0566S03.fn.pdf.

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

This filing is not anticipated to create a fiscal impact to small businesses, as this filing implements statutory requirements from Sections 26B-3-1202 and 26B-3-1203, enacted through HB 566. Any fiscal impact to small businesses resulting from resulting from HB 566 can be found in the fiscal note for this bill at https://pf.utleg.gov/public-web/sessions/2026GS/fiscal-notes/HB0566S03.fn.pdf.

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

This filing is not anticipated to create a fiscal impact to non-small businesses, as this filing implements statutory requirements from Sections 26B-3-1202 and 26B-3-1203, enacted through HB 566. Any fiscal impact to non-small businesses resulting from HB 566 can be found in the fiscal note for this bill at https://pf.utleg.gov/public-web/sessions/2026GS/fiscal-notes/HB0566S03.fn.pdf.

**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***)**:**

This filing is not anticipated to create a fiscal impact to other persons, as this filing implements statutory requirements from Sections 26B-3-1202 and 26B-3-1203, enacted through HB 566. Any fiscal impact to Medicaid members and entities outside of government or business resulting from HB 566 can be found in the fiscal note for this bill at https://pf.utleg.gov/public-web/sessions/2026GS/fiscal-notes/HB0566S03.fn.pdf.

**F. Compliance costs for affected persons:**

This filing is not anticipated to generate any compliance costs for affected persons, as it implements statutory requirements from Sections 26B-3-1202 and 26B-3-1203, enacted through HB 566. This bill's fiscal note can be found at https://pf.utleg.gov/public-web/sessions/2026GS/fiscal-notes/HB0566S03.fn.pdf.

## 6. Regulatory Impact Summary Table

Enter the cost or savings in the relevant cell. If there is no cost or savings, enter, "$0." If a cost or savings is inestimable, enter, "inestimable."

| **Fiscal Cost** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
|---|---|---|---|---|---|
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Cost** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Fiscal Benefits** | **FY2027** | **FY2028** | **FY2029** | **FY2030** | **FY2031** |
| State Budget | $0 | $0 | $0 | $0 | $0 |
| Local Governments | $0 | $0 | $0 | $0 | $0 |
| Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Non-Small Businesses | $0 | $0 | $0 | $0 | $0 |
| Other Persons | $0 | $0 | $0 | $0 | $0 |
| **Total Fiscal Benefits** | **$0** | **$0** | **$0** | **$0** | **$0** |
| **Net Fiscal Benefits** | **$0** | **$0** | **$0** | **$0** | **$0** |

## 7. Regulatory Impact Analysis Approval

The Commissioner of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

## 8. Family Impact Information

| **A. The agency has considered this rule's impact on family health, stability, and formation:** | ☒ |
|---|---|

**B. Summary of reasonable alternatives or modifications:**

**9. Citation Information**

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

| | | |
|---|---|---|
| Section 26B-1-213 | Section 26B-3-108 | Section 26B-3-1202 |
| Section 26B-3-1203 | | |

**10. Incorporation by Reference Information**

| **Incorporation by Reference** (if this rule incorporates more than two items by reference, please include additional tables)**:** | |
|---|---|
| **A. This rule adds or updates the following title of material incorporated by reference** (a copy of the material 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 or updates the following title of material incorporated by reference** (a copy of the material 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** | |

**11. Public Notice Information**

| **The public may submit written or oral comments to the agency identified in box 1.** | |
|---|---|
| **A. Comments will be accepted until:** | |

| **B. A public hearing (optional) will be held** (The public may request a hearing by submitting a written request to the agency, as outlined in Section 63G-3-302 and Rule R15-1.)**:** | | |
|---|---|---|
| **Date:** | **Time** (hh:mm AM/PM)**:** | **Place** (physical address or URL)**:** |
| | | |

**To the agency:** If more than one hearing is planned to take place, continue to add rows.

**12. Effective Date Information**

| **This rule change MAY become effective on:** (NOTE: This is the date the agency anticipates making the filing effective. It is NOT the effective date) | |
|---|---|

**13. Agency Authorization Information**

| **To the agency**: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date. | | | |
|---|---|---|---|
| **Agency head or designee and title:** | Tracy S. Gruber, Commissioner | **Date:** | 08/29/2026 |

**R414. Health and Human Services, Integrated Healthcare.**

**R414-340. Health Care Transparency and Accountability.**

**R414-340-1. Authority and Purpose.**

(1)(a) Sections 26B-3-1202 and 26B-3-1203 authorize this rule.

(b) This rule is in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936.

(2) This rule implements health care transparency and accountability specified in Sections 26B-3-1201, 26B-3-1202, and 26B-3-1203 by:

(a) establishing procedures for the Division of Integrated Healthcare (division) to develop and maintain a Medicaid data dashboard with information furnished by managed care plans; and

(b) setting forth obligations for a risk contractor or subcontractor regarding dashboard data submissions, improper payment identification and remediation, and sanctions for noncompliance with related requirements.

**R414-340-2. Definitions.**

Terms used in this rule are defined in Section 26B-3-1201.

**R414-340-3. Managed Care Organization Data Submission.**

(1) Consistent with Section 26B-3-1202, a risk contractor shall submit to the division in a division-specified format:

(a) total spending on non-claims expenditures, as required by the division;

(b) total spending on non-benefit services, as required by the division; and

(c) total spending on optional Medicaid benefits, including value add benefits, as required by the division.

(2) Each risk contractor shall submit an initial data report to the division with data described in Subsection (1) for the period of January 1, 2023, through September 30, 2026.

(3) The initial data report is due to the division by November 1, 2026.

(4)(a) Any report after the initial data report is due from the risk contractor by the first day of the month following the month after the preceding quarter.

(b) A risk contractor shall submit to the division the first quarterly report by February 1, 2027, for the period of October 1, 2026, through December 31, 2026.

(5) A risk contractor shall provide required data in a HIPAA-compliant manner consistent with 45 CFR 160, 162, and 164 (2026) and without protected health information.

(6) A risk contractor shall ensure each submitted data report complies with accessibility standards consistent with the Americans with Disabilities Act (ADA) Title II Web Regulation set forth in 28 CFR 35 (2026).

(7) Each managed care organization shall submit to the division complete copies of data, reports, and disclosures submitted to the Centers for Medicare and Medicaid Services (CMS) no later than 30 days after submission to CMS.

(a) A risk contractor shall redact a submission to the division as appropriate in compliance with HIPAA standards and requirements for public posting of information.

(b) A risk contractor shall ensure each redaction is consistent with the ADA Title II Web Regulation for accessibility set forth in 28 CFR 35.

**R414-340-4. Improper Payments and Corrective Action.**

(1) Consistent with Section 26B-3-1203, each risk contractor and subcontractor, as defined in Section 26B-1201, shall submit a quarterly report to the division in a division-specified format of:

(a) any improper payment;

(b) a root cause analysis for each type of improper payment; and

(c) the related corrective action plan for the improper payment.

(2) Each subcontractor shall submit a quarterly report to the parent risk contractor within 45 calendar days after the end of the preceding quarter.

(3) A risk contractor shall submit a quarterly report, including any subcontractor's report, as described in Subsection (2), to the division by the first day of the month following the month after the preceding quarter.

(4) A risk contractor shall submit to the division the first quarterly report by February 1, 2027, for the period of October 1, 2026, through December 31, 2026.

(5) A risk contractor shall repay the Department of Health and Human Services (department) for any improper payment, consistent with the managed care reimbursement model and the risk contractor's corresponding managed care contract, no later than 30 calendar days after the day on which the report described in Subsection (1) is due.

(6) A subcontractor shall repay the parent risk contractor for any improper payment no later than 30 calendar days after the day on which the report described in Subsection (2) is due to the parent risk contractor.

(7) A risk contractor shall correct the encounter data record, as appropriate, in accordance with the risk contractor's managed care contract with the department.

**R414-340-5. Noncompliance Penalties.**

The division shall assess any liquidated damage to a risk contractor that fails to submit a complete and timely report by the due date required by this rule, including any applicable subcontractor report, consistent with the risk contractor's contract with the division.

**KEY: Medicaid**
**Date of Last Change: 2026**
**Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108; 26B-3-1202; 26B-3-1203**

**State of Utah**
**Administrative Rule Analysis**
Revised May 2026

| NOTICE OF FIVE-YEAR REVIEW AND STATEMENT OF CONTINUATION | | |
|---|---|---|
| **Rule number:** | **R414-510** | **Filing ID: OFFICE USE ONLY** |

| | |
|---|---|
| **Effective date:** | **OFFICE USE ONLY** |

**1. Agency Information**

| | |
|---|---|
| **Title catchline:** | Health and Human Services, Integrated Healthcare |
| **Building:** | Cannon Health Building |
| **Street address:** | 288 N. 1460 W. |
| **City, state:** | Salt Lake City, UT |
| **Mailing address:** | 288 N. 1460 W. |
| **City, state and zip:** | Salt Lake City, UT 84116 |

**2. Contact Persons**

| **Name:** | **Phone:** | **Email:** |
|---|---|---|
| Craig Devashrayee | 801-915-4493 | cdevashrayee@utah.gov |
| Mariah Noble | 385-214-1150 | mariahnoble@utah.gov |

**Please address questions regarding information on this notice to the persons listed above.**

**3. General Information**

**A. Rule catchline:**

R414-510. Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education.

**B. Statutory provisions that authorize or require this rule and an explanation of those particular statutory provisions:**

| | |
|---|---|
| Section 26B-1-213 | Section 26B-1-213 authorizes the Department of Health and Human Services (department) to adopt rules as necessary to carry out the provisions of Title 26B, Utah Health and Human Services Code, including Medicaid program implementation. |
| Section 26B-3-108 | Section 26B-3-108 requires the department to implement the Medicaid program through administrative rules. |
| Section 26B-6-402 | Section 26B-6-402 sets forth provisions that promote independence, productivity, and integration in community life to serve people with disabilities. |

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

The department received written comments since the last five-year review that expressed concern that adjustments to the 365-day length-of-stay requirement represent a meaningful shift from the original intent of the policy. The commenter expressed that providers for individuals with intellectual disabilities have operated under the understanding that a 365-day placement allows time to stabilize individuals and recover the significant costs associated with admission and care. According to the commenter, expanding the definition to include time spent in other settings such as hospitals, other nursing facilities, or group homes begins to erode that framework. This could place providers in a difficult position. Additionally, the commenter explained that many step in to support individuals during complex or transitional periods in good faith and counting that time toward the 365-day requirement may result in providers not having sufficient time to offset the costs of care. Over time, the commenter believed this could create hesitation to accept or retain individuals with higher needs, which may limit access across the system.

The commenter further stated that the exception outlined in Subsection R414-510-3(2)(b) appears broad and may create challenges in consistent application. The commenter encouraged additional clarity or guardrails to ensure the 365-day requirement continues to serve the intended purpose of promoting stability and thoughtful transitions. Similarly, the commenter felt the language in Subsection R414-510-3(2)(g)(ii) referencing a "special bond or relationship" would benefit from further definition. As written, the commenter said, this phrase leaves room for subjective interpretation, which could lead to inconsistencies in how the rule is applied.

Finally, the commenter expressed concern that Subsection R414-510-3(2)(g)(iii) would not maintain a level playing field among providers and encouraged careful consideration to ensure that policy decisions do not unintentionally favor one provider type over another, particularly when each provider is working to meet the needs of this population.

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

Continuation of this rule is necessary because it implements the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF) voluntary transition program, which allows an individual to transition from a privately owned ICF to the Community Transitions Waiver. Without this rule, state oversight of this transition program would decrease and leave vulnerable populations at risk.

In response to the commenter, the department believes the 365-day length-of-stay provision should remain to include time spent in other settings, such as hospitals, other nursing facilities, or group homes. Since the inception of the program, the intent has been to assist individuals currently residing in ICFs to learn about their options, including the ability to remain in and continue receiving ICF services. For individuals selecting home and community-based services (HCBS), the department determined it would institute a yearlong waiting period with the intention to keep that requirement in place and accommodate breaks in stay within different types of settings, including HCBS programs.

The commenter denoted an additional apprehension about multiple exceptions to the 365-day timeframe. Current exceptions are seldom granted, and any new exceptions are similarly expected to be quite uncommon. The language was selected in such a way as to contemplate specific types of scenarios yet broad enough to allow the consideration of a variety of circumstances within each scenario. It is also important to note that in each case, apart from the closure of an ICF, exceptions require the submission of a written request including the rationale for the request and anticipated risk if the individual remains in the ICF. Moreover, the approval of such a written request must be made in concurrent agreement with the Division of Integrated Healthcare and the Division of Services for People with Disabilities. Within the span of a settlement agreement with the Disability Law Center, the department believes it has been judicious in making decisions about exceptions to the 365-day requirement with a limited number of approvals. When the department received requests that did not fit within the intended scope of the rule, the department denied those requests.

## 4. Agency Authorization Information

**To the agency:** Information requested on this form is required by Section 63G-3-305. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin*.

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| **Agency head or designee and title:** | Tracy S Gruber, Commissioner | **Date:** | 09/02/2026 |

**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 and Human Services, Integrated Healthcare.**
**R414-510. Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education.**
**R414-510-1. Introduction and Authority.**

(1) This rule implements the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF) transition program. The ICF transition program participation is voluntary and allows an individual to transition from a privately-owned ICF to the Community Transitions Waiver.

(2) This rule is authorized under Section 26B-3-108. Waiver services are optional and provided in accordance with 42 CFR 440.225.

**R414-510-2. Definitions.**

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

(2) "Division of Integrated Healthcare (DIH)" means the division within the department that administers the Medicaid program.

(3) "Division of Licensing and Background Checks (DLBC)" means the entity within the department that licenses foster homes, child care facilities, human services programs, and health facilities.

(4) "Division of Services for People with Disabilities (DSPD)" means the entity within the department that has responsibility to plan and deliver an appropriate array of services and supports to persons with disabilities in accordance with Subsection 26B-6-402(2).

(5) "Education and in-reach (EI) staff" means staff employed by the department to provide individuals with information and resources to help them make informed decisions about where they want to receive their long-term services and supports.

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

(7) "Healthcare decision-making" means decision-making as defined in Subsection 75-2a-103(12).

(8) "Home and community-based services (HCBS)" means person-centered care delivered in the home and community, designed to enable individuals to stay in their homes, rather than living in a facility for care.

(9) "Interested individual designation" means the status of an individual who resides in an ICF and expresses interest in participating in the ICF transition program.

(10) "ICF" means a privately owned intermediate care facility for individuals with intellectual disabilities.

(11) "Length-of-stay" means the length of time an individual has resided continuously in an ICF within the state. The department considers a continuous stay to include a stay in which an individual has a temporary break-in-stay of no more than 31 days.

(12) "Long-term services and supports (LTSS)" means a broad range of Medicaid- reimbursed assistance provided to individuals who experience difficulty completing self-care tasks as a result of an intellectual disability or related condition. LTSS may be provided in facilities or in HCBS settings.

(13) "Representative" means a person, who is not a legal guardian, but is identified as an individual who assists a potential transition program participant.

(14) "Transition worker" means a staff person employed by the department who is assigned to assist an individual who has expressed interest in moving into HCBS.

(15) "Supported decision-making (SDM) tool" means the form completed by EI staff to determine an individual's communication abilities and preferences, and to assist in supporting an individual's current ability to engage in decision-making.

(16) "Unable to determine interest designation" means the status of an individual who cannot clearly express in writing, or by any other means through which a reasonable person would recognize, a preference for where the individual wants to receive LTSS.

(17) "Undecided designation" means the status of an individual who has yet to make a decision about where to receive LTSS.

(18) "Waiver" means the Community Transitions Waiver, a Medicaid waiver program authorized under Subsection 1915(c) of the Social Security Act.

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

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

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

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

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

(d) meets state funding eligibility criteria for DSPD found in Subsection 26B-6-402(6); and

(e) has at least a 365-day length-of-stay in one, or any combination of, the following within the state:

(i) a Medicaid-certified ICF;

(ii) a nursing facility;

(iii) a hospital; or

(iv) a 1915(c) HCBS waiver program.

(2) The department may allow an exception to the requirements in Subsection (1)(e) if:

(a) there is a closure of an ICF where an individual resides;

(b) an individual mutually consents to transition into HCBS to the same residential provider with a sibling residing in an ICF who meets the 365-day length-of-stay requirement;

(c) a physician finds that continued ICF placement would exacerbate an individual's physical condition and a nurse with the department assesses that HCBS is appropriate through a health need assessment;

(d) a licensed mental health professional finds that continued ICF placement would exacerbate an individual's mental health condition and a nurse with the department assesses that HCBS is appropriate through a health heed assessment;

(e) Adult Protective Services (APS), Child Protective Services (CPS), the Office of Licensing (OL), or law enforcement substantiate evidence of abuse, neglect, or exploitation of an individual who resides in an ICF;

(f) a transition program employee within the department assesses that abuse, neglect, or exploitation occurred through a reasonable person standard that requires:

(i) direct observation; and

(ii) findings of facts that define abuse, neglect, or exploitation; or

(g) an individual mutually consents to transition into HCBS to the same residential provider with another individual who:

(i) has already met the 365-day length-of-stay requirement;

(ii) has an agreement with the individual that communicates a special bond or relationship; and

(iii) the preferred HCBS residential provider cannot hold an available placement to accommodate the individual who has not yet met the 365-day length-of-stay requirement.

(3) To request an exception for a reason in Subsections (2)(b) through (g), an individual or representative shall submit a written request to the department with the rationale for the request, including the anticipated risk if the individual remains in the ICF.

(4) Within ten business days of receiving the request, the department shall provide a written determination of approval or denial, made in concurrent agreement with the administrators responsible for waiver oversight at DIH and DSPD.

**R414-510-4. Department Responsibilities to Provide HCBS Education to Individuals Who Reside in ICFs.**

(1) EI staff shall:

(a) provide ongoing HCBS education, as described in Subsections (2) through (5), to each individual residing in an ICF;

(b) display transition program and staff contact information in conspicuous locations within each ICF;

(c) hold a recurring meeting at least four times a year available to every ICF resident, guardian, and representative that informs each attendee about the option to:

(i) visit an HCBS setting;

(ii) receive support from a peer who has experience moving from an ICF to HCBS; and

(iii) request a meeting with a peer; and

(d) upon the request of an individual, guardian, or representative, arrange a meeting between any requestor and a peer.

(2) EI staff shall provide education about the transition program and HCBS in a way that is responsive to each individual's method of communication, which may include:

(a) in-person discussion;

(b) communication by telephone or email;

(c) one-on-one or group discussion; and

(d) interaction in a community-based setting, including a:

(i) visit to an HCBS setting;

(ii) meeting with a peer who has experience moving from an ICF to HCBS; and

(iii) discussion with an HCBS provider.

(3) EI staff shall provide educational materials including through print or another medium.

(4) As EI staff provide ongoing HCBS education to any individual without a guardian:

(a) the individual may invite anyone to participate in the decision-making process to express whether the individual wants to participate in the transition program;

(b) EI staff shall work with the individual and anyone participating in the process; and

(c) EI staff shall document and act upon the individual's decision at each interval.

(5) As EI staff provide ongoing HCBS education to any individual with a guardian, EI staff shall work with the individual and the guardian on the decision-making process.

(a) If the guardian has decision-making authority on where the individual lives, EI staff shall rely on the decision rendered by the guardian regarding whether the individual will participate in the transition program.

(b) If the guardian's decision conflicts with the expressed interest of the individual, the transition worker shall:

(i) confirm the guardian's authority to make health care decisions;

(ii) request a meeting with the guardian to discuss the individual's expressed interest in accordance with Subsection 75-5-312(1)(e); and

(iii) provide the guardian with a copy of the department letter about involvement of the ward in decision-making to the extent possible and the responsibility of the guardian to consider the preferences of the individual.

(c)(i) EI staff shall inform each individual and guardian that the individual or guardian may express interest in participating in the transition program:

(A) at any time; and

(B) in writing, or by any other means through which a reasonable person would believe that the individual is interested in living in the community.

(ii) The individual or guardian retains the right to change the decision at any time.

(6) If an ICF administrator or employee discourages an individual, guardian, or representative, the department shall review the event and respond with an individualized approach to correct any misinformation the ICF administrator or employee may have provided, consistent with Subsection R414-510-5(5).

**R414-510-5. HCBS Education - ICF Responsibilities.**

(1)(a) To ensure that EI staff provide transition program education to individuals who reside in ICFs, their legal guardians, and to others the individual may identify to assist in the decision-making process, the ICF administrator shall submit to the department the contact information for each individual on a biannual basis, in July and January of each year.

(b) ICFs shall send updates to the department that include:

(i) names of each individual who resides at the facility and the individual's known personal contact information, including phone numbers and email addresses;

(ii) names of individuals, guardians, representatives, family members, and their known contact information including phone numbers, email addresses, and physical addresses.

(c) In between scheduled updates, as ICFs become aware of changes to contact information, ICFs shall communicate the changes in writing directly to the department within ten days of becoming aware of the change.

(2)(a) In accordance with the Utah Medicaid Provider Agreement signed by each ICF, the ICF administrator shall provide to department staff timely access to requested member records.

(b) ICFs shall fulfill written documentation requests they receive from the department within five business days of the request. The department shall report cases of non-compliance to DLBC for investigation.

(3) Within 90 days of ICF employment, ICF direct-care staff shall participate in HCBS general training. The department shall provide the training curriculum and include specialized training for the care of children and youth with intellectual disabilities. An ICF shall provide evidence of employee training records to the department upon request.

(4) The facility administrator and employees shall ensure the rights of individuals are protected and shall:

(a) provide the means for individuals and guardians to access information about HCBS;

(b) not discourage an individual from accessing information, making decisions about, learning about, or moving into HCBS; and

(c) provide necessary support for individuals who decide to move into HCBS.

(5) A facility administrator or employee is considered to have discouraged access to HCBS under Subsection (4)(b) if they seek to prevent member access by:

(a) limiting member access to information;

(b) providing false information;

(c) expressing disapproval to members in the ICF of HCBS

(d) seeking to impose individual goals for the individual to meet before seeking HCBS;

(e) preventing communication with department staff or other outside organizations; or

(f) interfering with or delaying an individual's move to HCBS.

(6) For allegations of non-compliance with Rule R414-510, the department shall:

(a) review the allegation with the ICF administrator and seek remedies to address the issue;

(b) track allegations, and if a pattern of recurrence is detected, require a written plan of correction from the provider; and

(c) refer cases to DLBC for investigation.

**R414-510-6. HCBS Education - Department Responsibilities.**

(1)(a) Before admission to an ICF, an individual or guardian shall contact EI staff to receive education about, and referral to, HCBS and local resources.

(b) For individuals under 22 years of age, the department shall perform an additional evaluation of services to determine whether HCBS are available to assure informed choice before admission to an ICF.

(c) The DIH director or designee, and the DSPD director or designee, shall authorize in writing ICF admissions of individuals under 22 years of age.

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

(e) Upon completing education and referral with EI staff, an individual who is over 22 years of age and decides to move into an ICF, shall be given a written confirmation verifying the education process occurred before admission.

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

(2)(a) Due to an urgent or emergent need, an individual may admit to an ICF immediately. EI staff shall provide education and assistance with resources after admission.

(b) An ICF shall:

(i) notify the department of the admission;

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

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

(c) EI staff shall provide education within 30 days of ICF admission unless an individual's health or other external factors make it necessary to provide education at a later date.

(d) Once EI staff provide education, the department shall provide the ICF with a written confirmation of the education form, and the ICF shall keep the form in the individual's medical record.

**R414-510-7. Categorizing Interest in the Transition Program.**

(1)(a) The department shall inform an individual or guardian that the individual or guardian may express interest in receiving HCBS:

(i) at any time; and

(ii) in writing or by any other means responsive to the individual's method of communication and through which a reasonable person would believe that the individual is interested in living in the community.

(b) The individual or guardian retains the right to amend the choice at any time.

(c) The department designates an individual's expression of interest into the following categories:

(a) interest in moving to HCBS;

(b) interest in learning more about HCBS;

(c) undecided;

(d) no interest in learning more about or moving to HCBS.

(2) Based on an individual's expression of interest in receiving HCBS, the department shall review the capacity of the Community Transitions Waiver and make efforts to increase capacity to address the interest.

**R414-510-8. Formal Decision-Making Process for Individuals Identified as Unable to Determine Interest.**

(1) To support the decision-making process, the department shall train EI staff on best practices and techniques to effectively communicate and best support individuals with intellectual disabilities during interactions, meetings, and interviews. The department shall also train staff on using SDM tools.

(2) EI staff shall meet routinely with an individual or guardian to determine interest in HCBS.

(3) For an individual whose preference has not been determined through routine meetings described in Section R414-510-4, and who does not have a guardian, EI staff shall use the SDM tool. EI staff shall use the SDM tool:

(a) to help organize and document what is observed when interacting with the person;

(b) to assist in developing strategies to improve individual access to communication; and

(c) to better gauge how a person indicates preferences and choice.

(4) Using information obtained from the SDM tool, EI staff shall work closely with the Utah Center for Assistive Technology and others to adapt communication methods to best meet the needs of each person.

(5) EI staff shall ensure American sign language and other language interpretation services are used when needed.

(6) EI staff shall use communication strategies identified through the SDM when engaging with individuals.

(7) If EI staff can determine an individual's preference after using these strategies, they then shall update the individual's interest designation according to the individual's identified preference.

(8)(a) For an individual whom EI staff continues to identify as unable to determine interest, the department shall take the following actions.

(b) For an individual with involved family members or friends, EI staff shall work with family to assist the individual with healthcare decision-making in accordance with Title 75, Chapter 2a, Advance Health Care Directive Act.

(c) For an individual who has family members or friends who are not involved in the individual's life, or if the individual does not have any known family members or friends to assist the individual with healthcare decision-making, EI staff shall refer the case to the Office of Public Guardian (OPG) for review.

**R414-510-9. Referring Undetermined Cases to the Office of Public Guardian (OPG).**

(1) For cases referenced in Section R414-510-8, OPG shall review an individual case to determine whether the case is in accordance with Subsection 75-2a-104(2).

(2) If OPG determines that an individual cannot decide where to receive long-term services and supports, it shall seek to work with family or friends, if known and available, to determine whether they can assist the individual with decision-making in accordance with Section 75-2a-108.

(3) If OPG cannot identify family members or friends for this role, it shall petition the court to obtain the least restrictive guardianship option available that will meet the needs of the individual.

**KEY: Medicaid**
**Date of Last Change: June 24, 2026**
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