DIH Rules Matrix 5-28-26

Rule Summary	Bulletin Publication	Effective
R414-510 Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education; This amendment clarifies existing requirements for program eligibility, responsibilities to inform individuals housed in intermediate care facilities (ICFs) regarding home and community-based services (HCBS), and provisions for program capacity based on individual interest in receiving HCBS.	**4-1-26**	**5-8-26**
R414-12 Laboratory Services (Five-Year Review); Continuation of this rule is necessary because this rule specifies the scope of mandatory laboratory services for Medicaid members, as required by federal law.	**5-15-26**	**4-27-26**
R414-49 Dental, Oral, and Maxillofacial Surgeons and Orthodontia; The purpose of this change is to implement SB 2 of the 2025 General Session and Utah's Medicaid Reform 1115 Demonstration Waiver. This amendment expands dental services to individuals eligible under EPSDT and to pregnant and postpartum women. It also updates eligibility requirements for individuals who qualify for dental services under the Emergency Services Program for Non-Citizens and updates reimbursement methodology for payments to dental providers under the Medicaid program.	**5-15-26**	**7-1-26**
R414-502 Nursing Facility Levels of Care; This amendment clarifies level of care criteria for the benefit of patients in nursing facilities and for the providers who treat them daily. It clarifies provisions for attending providers, cognitive functioning and testing, and specifies the meaning of orientation as it pertains to the daily activities of nursing facility patients.	**5-15-26**	**6-23-26**
R414-505 Participation in the Nursing Facility Non-State Government-Owned Upper Payment Limit Program (Five-Year Review); Continuation of this rule is necessary to fulfill statutory requirements for implementing the Medicaid program and to define the participation requirements in the nursing care facility non-state government-owned upper payment limit program.	**6-1-26**	**5-7-26**

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 2025

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Amendment		
Rule or section number:	**R414-510**	**Filing ID: OFFICE USE ONLY**
Date of previous publication (only for CPRs):		

Agency Information

1. 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	
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.		

General Information

2. Rule or section catchline:	
R414-510. Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education	
3. Are any changes in this filing because of state legislative action?	Changes are not because of legislative action.
If yes, any bill number and session:	
4. Purpose of the new rule or reason for the change:	
Based on internal review, the Department of Health and Human Services (department) has decided it is appropriate update this rule to clarify components of the transition to home and community-based services (HCBS).	
5. Summary of the new rule or change:	
This amendment clarifies existing requirements for program eligibility, responsibilities to inform individuals housed in intermediate care facilities (ICFs) regarding HCBS, and provisions for program capacity based on individual interest in receiving HCBS. Additionally, this amendment makes style and formatting changes to comply with the Rulewriting Manual for Utah and align with other rules under the department.	

Fiscal Information

6. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A. State budget:
There is no anticipated fiscal impact to the state budget as a result of this filing because these changes are meant to align this rule with existing practices. Department staff working with the intermediate care facility (ICF) transition program already implement the procedures and processes being clarified through this filing, including informing individuals housed in ICFs of their options to transition to home and community-based services (HCBS), enforcing program eligibility requirements, and accounting for individual interest in receiving HCBS as part of program capacity. Additional style and formatting changes do not add to, modify, or remove any processes in the program.
B. Local governments:
There is no anticipated 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)**:**
There is no anticipated fiscal impact to small businesses that are ICFs as a result of this filing because these changes are meant to align this rule with existing practices. Department staff working with the ICF transition program already implement the

procedures and processes being clarified through this filing, including informing individuals housed in ICFs of their options to transition to HCBS, enforcing program eligibility requirements, and accounting for individual interest in receiving HCBS as part of program capacity. Additional style and formatting changes do not add to, modify, or remove any processes at ICFs.

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

There is no anticipated fiscal impact to non-small businesses that are ICFs as a result of this filing because these changes are meant to align this rule with existing practices. Department staff working with the ICF transition program already implement the procedures and processes being clarified through this filing, including informing individuals housed in ICFs of their options to transition to HCBS, enforcing program eligibility requirements, and accounting for individual interest in receiving HCBS as part of program capacity. Additional style and formatting changes do not add to, modify, or remove any processes at ICFs.

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

There is no anticipated impact to other persons as a result of this filing because any changes in this filing only affect ICFs, which are exclusively small and non-small businesses, and ICF transition programs.

F. Compliance costs for affected persons:

There is no anticipated compliance cost for affected persons. Department staff working with the ICF transition program already implement the procedures and processes being clarified through this filing, including informing individuals housed in ICFs of their options to transition to HCBS, enforcing program eligibility requirements, and accounting for individual interest in receiving HCBS as part of program capacity. Additional style and formatting changes do not add to, modify, or remove any processes at ICFs.

G. Regulatory Impact Summary Table (This table includes only fiscal impacts the agency was able to measure. If the agency could not estimate an impact, it is excluded from this table but described in boxes A through F.)

Regulatory Impact Summary Table

Fiscal Cost	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
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	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
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**

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

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

Citation Information

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

Section 26B-1-213	Section 26B-3-108	Section 26B-6-402

Incorporation by Reference Information

8. 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	

Public Notice Information

9. 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.		

10. This rule change MAY become effective on:	
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 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, Executive Director	**Date:**	03/15/2026

R414. Health and Human Services, Integrated Healthcare.
R414-510. Intermediate Care Facility for Persons with Intellectual Disabilities Transition Program and Education.
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[~~12 month~~] length-of-stay in one, or any combination of, the following within the state:[~~any~~]
(i) a Medicaid-certified[~~, privately owned~~] ICF;[~~or nursing facility located in the state.~~]
(ii) a nursing facility;
(iii) a hospital; or
(iv) a 1915(c) HCBS waiver program.
(2) The department may allow[~~s~~] [~~break in stay~~]an exception[~~s~~] to the requirements in Subsection (1)(e) if[~~for~~]:
[~~(a) inpatient hospitalization;~~
~~(b) admission to a nursing facility; or~~
~~(3) The department may also allow break in stay exceptions:~~]
([~~e~~]a) [~~due to the~~]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.[

~~(a) due to substantiated findings of abuse; and~~

~~(b) neglect or exploitation of an individual that occurred while residing in the current ICF.~~]

([4]3) To request an [~~length of stay~~]exception for [~~the~~]a reason[~~s~~] [~~noted~~]in Subsection ([~~3~~]2)(b) through (g)[~~(a)(b)~~], an individual or representative shall submit a written request to the department [~~and~~]with [~~include~~]the rationale for the request, including the anticipated risk if the individual remains in the ICF.

([~~5~~]4) [~~T~~]Within ten business days of receiving the request, the department shall provide a written determination [~~to~~]of approval[~~e~~] or denial, made in concurrent agreement with the administrators responsible for waiver oversight at DIH and DSPD[~~y the request within ten business days of receiving it~~].

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[~~residents and shall:~~];

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

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

([~~c~~]i) [~~provide opportunities for ICF residents, guardians, or representatives to~~]visit an HCBS setting[~~s~~];[~~ and~~]

([~~d~~]ii) [~~provide opportunities for ICF residents, guardians, or representatives to~~]receive support from a peer[~~s~~] who ha[~~ve~~]s experience[~~d~~] 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 [~~multiple~~]a way[~~s~~] that is[~~and in a manner~~] responsive to each [~~person~~]individual's method of communication[~~. Examples~~], which may include:

(a) in-person discussion[~~s~~];

(b) communication by telephone or email;

(c) one-on-one or group discussion[~~s~~]; and

([~~c~~]d) interaction[~~s~~] in a community-based setting[~~s~~], 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[~~and~~

~~(d) communication by telephone or through email~~].

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

(4) As EI staff provide ongoing HCBS education [~~about HCBS~~]to any individual[~~s~~] without a guardian[~~s~~,]:

(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[~~ the individual invites to participate to express whether the individual wants to participate in the transition program.~~]

(c) [~~At each interval, ~~]EI staff shall document and act upon the individual's decision at each interval.

(5)[~~(a)~~] As EI staff provide ongoing HCBS education[~~ about HCBS is provided~~] to any individual[~~s~~] with a guardian[~~s~~], EI staff shall work with the individual and the guardian on the decision-making process[~~and the individual~~].

(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 guardian wants~~]the individual [~~to~~]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 [~~to guardians~~]about involvement of the ward in decision-making to the extent possible[~~,~~] and the responsibility of the guardian to [~~take into account~~]consider the preferences of the individual.

([~~6~~]c)(i) EI staff shall inform each individual[~~s~~] [~~or~~]and guardian[~~s~~] that the[~~y~~] 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.[~~ Interest may be expressed at any time before or after EI staff contact the individual or their guardian, and t~~]

(ii) The individual or guardian retains the right to change [~~a~~]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).

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

(1)(a) The department shall inform an individual or guardian that the[~~y~~] 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) [~~Interest may be expressed at any time before or after EI staff make direct contact with the individual or guardian, and t~~]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:

([~~1~~]a) interest in moving to HCBS;

([~~2~~]b) interest in learning more about HCBS;

([~~3~~]c) undecided;

([~~4~~]d) no interest in learning more about or moving to HCBS[~~; and~~

~~(5) unable to determine interest~~].

(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.

KEY: Medicaid
Date of Last Change: [~~January 1, 2024~~]2025
Notice of Continuation: September 14, 2021
Authorizing, and Implemented or Interpreted Law: 26B-3-108; 26B-6-402[~~; Title 75, Chapter 2a~~]

State of Utah
Administrative Rule Analysis
Revised May 2025

NOTICE OF FIVE-YEAR REVIEW AND STATEMENT OF CONTINUATION		
Rule number:	**R414-12**	**Filing ID: OFFICE USE ONLY**
Effective date:	**OFFICE USE ONLY**	

Agency Information

1. 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	
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.		

General Information

2. Rule catchline:	
R414-12. Laboratory Services	
3. Statutory provisions that authorize or require this rule and an explanation of those particular statutory provisions:	
Section 26B-1-213	Section 26B-1-213 grants the Department of Health and Human Services (department) the authority to adopt, amend, or rescind rules necessary to carry out the provisions of Title 26B, Utah Health and Human Services Code.
Section 26B-3-108	Section 26B-3-108 requires the department to implement the Medicaid program through administrative rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:	
No comments have been received since the last five-year review of this rule.	
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:	
Continuation of this rule is necessary because this rule specifies the scope of mandatory laboratory services for Medicaid members, as required by federal law. As there were no comments in opposition to this rule, the department did not respond to any such comments.	

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, Executive Director	**Date:**	04/24/2026
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, Health Care Financing, Finance Policy.
R414-12. Laboratory Services.
R414-12-1. Purpose and Authority.

(1) Laboratory services provide a scope of services to meet the basic medical needs of eligible Medicaid members.
(2) Laboratory services are a mandatory Medicaid service authorized by Title XIX of the Social Security Act.
(3) Sections 26B-1-213 and 26B-3-108 authorize this rule.

R414-12-2. Definitions.

(1) "COT" means chronic opioid therapy.

(2) "SUD" means substance use disorder.

(3) "Presumptive and qualitative drug testing" means testing used to determine the presence or absence of drugs or drug classes in a urine sample, with results expressed as negative, positive, or as a numerical result, and includes competitive immunoassays and thin layer chromatography.

(4) "Definitive quantitative confirmation" means to identify specific medications, illicit substances, and metabolites, which report the results of analytes absent or present typically in nanogram per milliliter concentrations. Definitive methods include gas chromatography-mass spectrometry and lethal concentration-tandem mass spectrometry testing methods.

R414-12-3. Eligibility Requirements.

Laboratory services are available to each eligible Medicaid member.

R414-12-4. Program Access Requirements.

An eligible Medicaid member may obtain laboratory services from any Utah Medicaid provider.

R414-12-5. Service Coverage and Limitations.

(1) Medicaid covers urine drug testing if medically necessary for COT or SUD as follows:

(a) annual quantity limits of 60 presumptive tests and 16 definitive tests; and

(b) daily quantity limits of one presumptive test and one definitive test.

(2) Medicaid evaluates quantity limit exceptions on a case-by-case basis.

KEY: Medicaid
Date of Last Change: October 30, 2023
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2025

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Amendment		
Rule or section number:	**R414-49**	**Filing ID: OFFICE USE ONLY**
Date of previous publication (only for CPRs):		

Agency Information

1. 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	
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.		

General Information

2. Rule or section catchline:	
R414-49. Dental, Oral, and Maxillofacial Surgeons and Orthodontia	
3. Are any changes in this filing because of state legislative action?	Changes are because of legislative action.
If yes, any bill number and session:	SB 2 (2025 General Session)
4. Purpose of the new rule or reason for the change:	
The purpose of this change is to implement SB 2 of the 2025 General Session and Utah's Medicaid Reform 1115 Demonstration Waiver, which expands dental services to individuals eligible under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program and to pregnant and postpartum women.	
5. Summary of the new rule or change:	
This amendment expands dental services to individuals eligible under EPSDT and to pregnant and postpartum women. It also updates eligibility requirements for individuals who qualify for dental services under the Emergency Services Program for Non-Citizens and updates reimbursement methodology for payments to dental providers under the Medicaid program.	

Fiscal Information

6. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A. State budget:
The Department of Health and Human Services (department) does not expect additional funding to provide dental services to individuals eligible under EPSDT and to pregnant and postpartum women, other than what the Legislature previously appropriated through SB 2 during the 2025 General Session. The University of Utah School of Dentistry (UUSOD) will seed money for the department to pay the state share of payments to dental providers for their services. SB 2 estimates $19,900,800 in general funds savings. As SB 2 accounts for this amount, no additional cost or savings is reflected in the regulatory impact summary table for this filing.
B. Local governments:
There is no anticipated impact on local governments as they neither fund nor provide dental services under the Medicaid program.
C. Small businesses ("small business" means a business employing 1-49 persons)**:**
Small businesses are expected to see an increase in revenue due to the expansion of services, but this increase cannot be measured with current data available on the quantity or types of services that individuals eligible under EPSDT and pregnant and postpartum women may require.

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

Non-small businesses are expected to see an increase in revenue due to the expansion of services, but this increase cannot be measured with current data available on the quantity or types of services that individuals eligible under EPSDT and pregnant and postpartum women may require.

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***)**:**

Other persons are expected to see an increase in revenue and out-of-pocket savings due to the expansion of services, but this increase cannot be measured with current data available on the quantity or types of services that individuals eligible under EPSDT and pregnant and postpartum women may require.

F. Compliance costs for affected persons:

The department does not expect compliance costs for UUSOD because it is only seeding the money, accounted for in SB 2, and not treating additional patients. There is a network of dentists or providers throughout the state to provide necessary dental care. Further, the department does not expect additional compliance costs to other entities because there is only a change in funding the program from general funds to seed money provided by UUSOD.

G. Regulatory Impact Summary Table (This table includes only fiscal impacts the agency was able to measure. If the agency could not estimate an impact, it is excluded from this table but described in boxes A through F.)

Regulatory Impact Summary Table

Fiscal Cost	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
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	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
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**

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

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

Citation Information

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

Section 26B-1-213	Section 26B-3-108	Section 26B-3-208

Incorporation by Reference Information

8. 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	

Public Notice Information

9. The public may submit written or oral comments to the agency identified in box 1.		
A. Comments will be accepted until:		06/16/2026
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)**:**
Click or tap to enter a date.		
To the agency: If more than one hearing is planned to take place, continue to add rows.		

10. This rule change MAY become effective on:	07/01/2026
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 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, Executive Director	**Date:**	05/01/2026

R414. Health and Human Services, Integrated Healthcare.
R414-49. Dental, Oral, and Maxillofacial Surgeons and Orthodontia.
R414-49-1. Authority and Purpose.

(1)(a) Sections 26B-1-213, 26B-3-108, and 26B-3-[~~108~~]208 authorize this rule.

(b) A service provided under this rule is authorized by a federal Section 1115 waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services.

(2) This rule [~~provides a~~]defines the scope of dental, oral, and maxillofacial surgery and orthodontia services for Medicaid members[~~in accordance with Section 26B-3-208~~].

R414-49-2. Definitions.

Terms used in this rule are defined in Rule R414-1. [-]Additionally:

(1) "Acute" means referring to a disease or illness of sudden onset and brief course, not chronic.

([~~1~~]2) "Anterior tooth" means tooth numbers:

(a) 6 through 11;

(b) 22 through 27;

(c) C through H; and

(d) M through R.

(3) "Chronic" means a persistent condition in relation to a disease or illness.

([~~2~~]4)(a) "Dental service[~~s~~]" [~~whether furnished in a hospital, an office, a skilled nursing facility, or anywhere else,~~]means a covered service[~~s~~] performed within the scope of a Medicaid-enrolled dental provider's license as defined in Title 58, Occupations and Professions.

(b) A dental service may occur whether furnished in a hospital, an office, a skilled nursing facility, or elsewhere.

(5) "Diagnosis" means the identification of a disease or condition.

([~~3~~]6) "Posterior tooth" means tooth numbers:

(a) 1 through 5;

(b) 12 through 21;
(c) 28 through 32;
(d) A through B;
(e) I through L; and
(f) S through T.

(7) "PRISM" means Provider Reimbursement Information System for Medicaid.

R414-49-3. Client Eligibility Requirements.

(1) Comprehensive, preventive, and medically necessary diagnostic and treatment services are available to members eligible under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

(2) Comprehensive dental benefits are available to adult members 21 years of age and older.

(3) For individuals enrolled in the Emergency Services Program for Non-Citizens, coverage is limited to the treatment of a qualifying emergency dental condition as outlined in Subsection R414-49-5(5).

R414-49-[~~3~~]4. [~~Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)~~]Program Access Requirements.

(1) A Medicaid-enrolled provider who is also affiliated with the University of Utah School of Dentistry Medicaid Associated Provider Program shall perform each dental service.

(2) A provider shall verify a member's eligibility for dental services through the Medicaid eligibility system on each date of service before the rendering of a dental or surgical procedure.

(3) A provider shall determine the coverage, limitations, quantity limits, and prior authorization (PA) requirements for each service before delivery.

(4) Any service requiring PA must obtain approval before the service is provided. Medicaid does not cover services provided without an approved PA.

(5) A provider may verify the coverage of a particular service based on a member's enrollment eligibility status by using the PRISM Coverage and Reimbursement Code Look-up Tool found on the Utah Medicaid website.

(6) Further details, clinical criteria, and guidance for the coverage of dental services are outlined in the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual.

(7) To ensure member access, a provider must maintain accurate directory information in the PRISM portal, including specialty and linguistic capabilities.

(8) Any dental service, including a medical necessity exception, is provided through a fee-for-service delivery system.[

~~This section defines the scope of dental services available to a member who is eligible under the EPSDT program and includes comprehensive and preventive health care services.~~

~~(1) Dental services shall only be available through a Medicaid-enrolled dental provider that complies with relevant laws and policy.~~

~~(2) Dental services shall only be provided within the parameters of generally accepted standards of dental practice and may be subject to any limitation or exclusion established by Medicaid.~~

~~(3) Dental services may be subject to any limitation or exclusion of medical necessity and utilization control considerations or conditions.~~

~~(4) Medicaid shall reimburse up to one evaluation for each member each day, even if more than one provider is involved from the same office or clinic. Medicaid may not cover multiple exams for the same date of service.~~

~~(5) Medicaid includes in the global payment, and may not reimburse separately, any denture adjustment performed by the original provider within six months of a member receiving a denture.~~

~~(6) Medicaid may cover third molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove any remaining third molar during the same procedure.~~

~~(7) Medicaid shall cover the treatment of a temporomandibular joint fracture but may not cover other temporomandibular joint treatments.~~

~~(8) A laboratory or pathologist must submit a claim directly to Medicaid for payment of laboratory services.~~

~~(9) Medicaid may not cover the following dental services:~~

~~(a) cast crowns, porcelain fused to metal, on posterior permanent teeth or on primary teeth;~~

~~(b) consultation or second opinions not requested by Medicaid;~~

~~(c) dental implants;~~

~~(d) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth;~~

~~(e) fixed bridges or ponties;~~

~~(f) general anesthesia for removal of an erupted tooth;~~

~~(g) house calls;~~

~~(h) limited orthodontic treatment, including removable appliance therapies;~~

~~(i) nitrous oxide analgesia;~~

~~(j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;~~

~~(k) oral sedation for behavior management;~~

~~(l) osteotomies;~~

~~(m) procedures such as arthrostomy, meniscectomy, or condylectomy;~~

~~(n) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;~~

~~(o) removable appliances in conjunction with fixed banded treatment;~~
~~(p) ridge augmentation;~~
~~(q) temporary dentures or temporary stayplate partial dentures;~~
~~(r) tooth transplantation;~~
~~(s) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies; and~~
~~(t) services provided without prior authorization.~~
~~(10) A Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes responsibility for the difference in fees for covered anterior stainless steel crowns that are deciduous to non-covered anterior stainless steel crowns with composite facings added or commercial or lab-prepared facings.~~]

R414-49-[4]5. [~~Pregnant Members~~|Service Coverage.

(1) A dental provider shall provide each dental service within generally accepted standards of dental practice and subject to limitations of medical necessity and utilization control.
(2) The following limitations apply to coverage of dental services.
(a) Medicaid covers up to one evaluation for one member each day.
(b) A denture adjustment by the original furnishing provider within six months of delivery is included in the global payment.
(c) Third-molar extractions are covered when at least one third molar has documented pathology requiring extraction.
(d) Coverage of a dental service to the temporomandibular joint (TMJ) is limited to the treatment of TMJ fractures.
(e) Medicaid covers alveoloplasty and vestibuloplasty procedures for eligible adult populations effective January 1, 2025.
(3) Medicaid may cover an otherwise excluded dental service for an EPSDT eligible member if the department determines the service is medically necessary to correct or ameliorate a condition discovered as part of a screening.
(4) Unless authorized under Subsection (3), Medicaid does not cover a dental implant, fixed bridge, ridge augmentation, tooth transplantation, nitrous oxide, or oral sedation for behavior management.
(5) Emergency dental coverage is restricted to treating a sudden and acute onset of a condition where delay would jeopardize health, specifically:
(a) tooth eruption; or
(b) drainage of an abscess.
(6) A member may upgrade a covered service to a non-covered service, such as anterior stainless-steel crowns with facings, by assuming financial responsibility for the fee difference. The fee difference is determined by subtracting the provider's usual and customary charges of the base version from the usual and customary charges of the upgraded version.[~~ This section defines the scope of dental services available to a pregnant member who is eligible for Traditional Medicaid.~~
~~(1) Dental services shall extend up to the end of the 12th month after pregnancy ends.~~
~~(2) Dental services shall only be available through an enrolled dental provider that complies with relevant laws and policy.~~
~~(3) Dental services shall only be provided within the parameters of generally accepted standards of dental practice and may be subject to any limitation or exclusion established by Medicaid.~~
~~(4) Dental services may be subject to any limitation or exclusion of medical necessity and utilization control considerations or conditions.~~
~~(5) Medicaid shall reimburse up to one evaluation for each member each day, even if more than one provider is involved from the same office or clinic. Medicaid may not cover multiple exams for the same date of service.~~
~~(6) Medicaid includes in the global payment, and may not reimburse separately, any denture adjustment performed by the original provider within six months of a member receiving a denture.~~
~~(7) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove any remaining third molar during the same procedure.~~
~~(8) Medicaid shall cover the treatment of a temporomandibular joint fracture but may not cover other temporomandibular joint treatments.~~
~~(9) A laboratory or pathologist must submit a claim directly to Medicaid for payment of laboratory services.~~
~~(10) Medicaid may not cover the following dental services:~~
~~(a) cast crowns, porcelain fused to metal, on posterior permanent teeth or on primary teeth;~~
~~(b) consultation or second opinions not requested by Medicaid;~~
~~(c) dental implants;~~
~~(d) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth;~~
~~(e) fixed bridges or ponties;~~
~~(f) general anesthesia for removal of an erupted tooth;~~
~~(g) house calls;~~
~~(h) limited orthodontic treatment, including removable appliance therapies;~~
~~(i) nitrous oxide analgesia;~~
~~(j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;~~
~~(k) oral sedation for behavior management;~~
~~(l) osteotomies;~~
~~(m) procedures such as arthrostomy, meniscectomy, or condylectomy;~~
~~(n) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;~~
~~(o) removable appliances in conjunction with fixed banded treatment;~~

~~(p) ridge augmentation;~~
~~(q) temporary dentures or temporary stayplate partial dentures;~~
~~(r) tooth transplantation;~~
~~(s) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies; and~~
~~(t) services provided without prior authorization.~~
~~(11) A Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes responsibility for the difference in fees for covered anterior stainless steel crowns that are deciduous to non-covered anterior stainless steel crowns with composite facings added or commercial or lab-prepared facings.~~]

R414-49-[5]6. [~~Adult Members 21 Years of Age and Older and Not Eligible on the Basis of Pregnancy~~]Reimbursement Methodology.

The department reimburses dental services as outlined in attachment 4.19-B of the Utah Medicaid State Plan, incorporated by reference in Rule R414-1.[~~This section defines the scope of dental services available to an adult member who is 21 years of age or older and not eligible on the basis of pregnancy.~~
~~(1) Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act.~~
~~(2)(a) Dental services shall only be available through an enrolled dental provider that complies with relevant laws and policy.~~
~~(b) Dental services shall only be available through the University of Utah School of Dentistry and its associated in-state provider network.~~
~~(3) Dental services shall only be provided within the parameters of generally accepted standards of dental practice and may be subject to any limitation or exclusion established by Medicaid.~~
~~(4) Dental services may be subject to any limitation or exclusion of medical necessity and utilization control considerations or conditions.~~
~~(5) Medicaid shall reimburse up to one evaluation for each member each day, even if more than one provider is involved from the same office or clinic. Medicaid may not cover multiple exams for the same date of service.~~
~~(6) Medicaid includes in the global payment, and may not reimburse separately, any denture adjustment performed by the original provider within six months of a member receiving a denture.~~
~~(7) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove any remaining third molar during the same procedure;~~
~~(8) Medicaid shall cover the treatment of a temporomandibular joint fracture but may not cover other temporomandibular joint treatments.~~
~~(9) A laboratory or pathologist must submit a claim directly to Medicaid for payment of laboratory services.~~
~~(10) Medicaid may not cover the following dental services:~~
~~(a) consultation or second opinions not requested by Medicaid;~~
~~(b) dental implants;~~
~~(c) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth;~~
~~(d) fixed bridges or ponties;~~
~~(e) general anesthesia for removal of an erupted tooth;~~
~~(f) house calls;~~
~~(g) limited orthodontic treatment, including removable appliance therapies;~~
~~(h) nitrous oxide analgesia;~~
~~(i) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;~~
~~(j) oral sedation for behavior management;~~
~~(k) osteotomies;~~
~~(l) procedures such as arthrostomy, meniscectomy, or condylectomy;~~
~~(m) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;~~
~~(n) removable appliances in conjunction with fixed banded treatment;~~
~~(o) ridge augmentation;~~
~~(p) temporary dentures or temporary stayplate partial dentures;~~
~~(q) tooth transplantation;~~
~~(r) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies; and~~
~~(s) services provided without prior authorization.~~

~~**R414-49-6. Emergency Dental.**~~
~~This section defines the scope of dental services available to members who are otherwise eligible under the Medicaid program.~~
~~(1) Emergency dental services shall only be available through a Medicaid-enrolled dental provider that complies with relevant laws and policy.~~
~~(2)(a) An emergency dental service is the treatment of a sudden and acute onset of a dental condition that requires immediate treatment when delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.~~
~~(b) An emergency dental service is limited to the treatment of:~~

~~(i) a tooth eruption; or~~
~~(ii) drainage of an abscess.~~]

KEY: Medicaid
Date of Last Change: [~~April 1, 2025~~]2026
Notice of Continuation: May 29, 2024
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108; 26B-3-208

State of Utah
Administrative Rule Analysis
Revised May 2025

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Amendment		
Rule or section number:	**R414-502**	**Filing ID: OFFICE USE ONLY**
Date of previous publication (only for CPRs):		

Agency Information

1. 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	
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.		

General Information

2. Rule or section catchline:

R414-502. Nursing Facility Levels of Care.

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

4. Purpose of the new rule or reason for the change:

Upon internal review, the department determined this filing is necessary to clarify level of care criteria for patients who reside in nursing facilities.

5. Summary of the new rule or change:

This amendment clarifies level of care criteria for the benefit of patients in nursing facilities and for the providers who treat them daily. It clarifies provisions for attending providers, cognitive functioning and testing, and specifies the meaning of orientation as it pertains to the daily activities of nursing facility patients.

Additionally, it makes style and formatting changes to comply with the Rulewriting Manual for Utah and align more closely with other rules under the Department of Health and Human Services.

Fiscal Information

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

A. State budget:

The Department of Health and Human Services (department) does not expect any fiscal impact on the state budget as a result of this amendment because the amendment clarifies existing level of care criteria for nursing facility patients. This clarification neither affects current patient services nor payments to providers.

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 does not expect any fiscal impact on small businesses as a result of this amendment because this amendment clarifies existing level of care criteria for nursing facility patients. This clarification neither affects current patient services nor payments to providers.

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

The department does not expect any fiscal impact on non-small businesses as a result of this amendment because this amendment clarifies existing level of care criteria for nursing facility patients. This clarification neither affects current patient services nor payments to providers.

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 any fiscal impact on other persons or entities as a result of this amendment because this amendment clarifies existing level of care criteria for nursing facility patients. This clarification neither affects current patient services nor payments to providers.

F. Compliance costs for affected persons:

The department does not expect any compliance costs for affected persons as a result of this amendment because this amendment clarifies existing level of care criteria for nursing facility patients. This clarification neither affects current patient services nor payments to providers.

G. Regulatory Impact Summary Table (This table includes only fiscal impacts the agency was able to measure. If the agency could not estimate an impact, it is excluded from this table but described in boxes A through F.)

Regulatory Impact Summary Table

Fiscal Cost	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
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	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
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**

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

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

Citation Information

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

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

Incorporation by Reference Information

8. 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	

Public Notice Information

9. 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.		

10. This rule change MAY become effective on:	
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 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, Executive Director	**Date:**	04/19/2026

R414. Health and Human Services, Integrated Healthcare.
R414-502. Nursing Facility Levels of Care.
R414-502-2. Definitions.

[~~The definitions~~]Terms used in this rule are defined in Sections R414-1-2 and [~~Section~~]R414-501-2[~~ apply to this rule~~]. Additionally:

(1) "Attending provider" means a medical doctor or doctor of osteopathic medicine, physician assistant, advanced practice registered nurse, or nurse practitioner who is:

(a) duly licensed or certified; and

(b) responsible for the overall care of the patient including diagnosis, treatment, and follow-up.

(2)(a) "Cognitive testing" means testing used to diagnose a condition that includes questions about memory, executive function, language, visuospatial abilities, or orientation.

(b) Cognitive testing may include a Mini-Mental Status Examination or Montreal Cognitive Assessment.

(3) "Orientation" means a person's ability to understand and be aware of:

(a) person, including recognizing themselves and others around them;

(b) place, including understanding where the person is located; and

(c) time, including knowing the current date, day of the week, and time of day.

R414-502-3. Approval of Level of Care.

(1) The [~~D~~]department shall document that at least two of the [~~following~~]factors listed in Subsections (1)(a) through (1)(c) exist when [~~it determines~~]determining whether an applicant has a [~~mental~~]cognitive or physical condition[~~s~~] that requires the level of care provided in a nursing facility or equivalent care provided through a Medicaid home and community-based services (HCBS) waiver program[~~:~~].

(a)(i) [~~d~~]Due to a diagnosed medical condition[~~s~~], the applicant requires substantial ongoing physical assistance with multiple categories of activities of daily living[~~ activities~~] above the level of verbal prompting, supervising, or setting up.

(ii) Each program using level of care criteria shall determine a list of activities of daily living that would qualify an applicant for that program based on the type of setting.

(b) [~~t~~]The attending [~~physician~~]provider has [~~determined~~]diagnosed and documented that the applicant's [~~level of~~]ongoing cognitive dysfunction [~~in orientation to person, place, or time~~]is not related to an acute condition and requires long-term nursing facility care[~~,~~] or equivalent care provided through a Medicaid home and community-based waiver program.

(i) The attending provider shall evidence any cognitive dysfunction by conducting current cognitive testing and documentation.

(ii) Cognitive dysfunction may include disorientation.[~~; or~~]

(c) [~~t~~]The applicant's medical condition and intensity of services indicate that the long-term care needs of the applicant cannot be safely met in a less structured setting[~~,~~] or without the services and supports of a Medicaid home and community-based waiver program.

(2)(a) The [~~D~~]department shall determine whether at least two of the factors described in Subsection (1) exist by reviewing [~~the following~~]clinical documentation.

(b) Required clinical documentation varies between specific programs based on the type of setting.

(c) Required documentation for an HCBS waiver program is described in waiver implementation plans approved by the Centers for Medicare and Medicaid Services (CMS).

(d) A nursing facility provider shall include in the required clinical documentation:

([~~a~~]i) an applicant's current history and physical examination completed by an attending [~~physician~~]provider;

([~~b~~]ii) a comprehensive resident assessment for an applicant, completed, coordinated, and certified by a registered nurse;

([~~c~~]iii) a social services evaluation of an applicant that meets the criteria in 42 CFR 456.370[~~-and~~], completed by a person licensed as a social worker, or with a higher degree of training and licensure;

([~~d~~]iv) a written plan of care for an applicant established by an attending[~~physician~~]provider;

([~~e~~]v) an attending [~~physician's~~]provider's written certification that [~~the~~]an applicant requires nursing facility placement;[~~and~~]

(vi) weekly narrative nursing summaries that outline the care required and include the three factors of level of care criteria;

(vii) daily documentation of physical assistance given to an applicant for activities of daily living;

(viii) applicable and current cognitive testing with associated narrative charting related to an applicant's cognitive need with examples of impact;

(ix) any applicable pre-admission screening and resident review evaluation, in accordance with Rule R414-503;

([~~f~~]x) documentation indicating that less restrictive alternatives or services to prevent or defer nursing facility care for an applicant have been explored;

(xi) the cognitive dysfunction attestation form published by the department; and

(xii) any other pertinent documentation related to the factors described in Subsection (1).

(3) If the [~~D~~]department finds that at least two of the factors described in Subsection (1) exist, the [~~D~~]department shall determine whether the applicant meets criteria for nursing facility level of care and is medically approved for Medicaid reimbursement of nursing facility services or equivalent care provided through a Medicaid home and community-based waiver program.

(a) Meeting medical eligibility for nursing facility services does not guarantee Medicaid payment.

(b) Financial eligibility and other home and community-based waiver targeting criteria apply.

KEY: Medicaid
Date of Last Change: [~~July 28, 2025~~]2026
Notice of Continuation: May 29, 2024
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108

State of Utah
Administrative Rule Analysis
Revised May 2025

NOTICE OF FIVE-YEAR REVIEW AND STATEMENT OF CONTINUATION		
Rule number:	**R414-505**	**Filing ID: OFFICE USE ONLY**
Effective date:	**OFFICE USE ONLY**	

Agency Information

1. 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	
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.		

General Information

2. Rule catchline:	
R414-505. Participation in the Nursing Facility Non-State Government-Owned Upper Payment Limit Program.	
3. Statutory provisions that authorize or require this rule and an explanation of those particular statutory provisions:	
Section 26B-1-213	This section grants the Department of Health and Human Services (department) the authority to adopt, amend, or rescind rules.
Section 26B-3-108	This section requires the department to implement the Medicaid program through administrative rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:	
No comments have been received since the last five-year review of this rule.	
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:	
Continuation of this rule is necessary to fulfill statutory requirements for implementing the Medicaid program and to define the participation requirements in the nursing care facility non-state government-owned upper payment limit program.	

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:**	
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, Health Care Financing, Coverage and Reimbursement Policy.
R414-505. Participation in the Nursing Facility Non-State Government-Owned Upper Payment Limit Program.
R414-505-1. Purpose and Authority.

(1) This rule defines the participation requirements in the nursing care facility non-state government-owned upper payment limit (NF NSGO UPL) program.

(2) This rule is authorized under Attachment 4.19-D of the Medicaid State Plan, and by Sections 26B-1-213 and 26B-3-108.

R414-505-2. Definitions.

In addition to the following, the definitions in Section 26B-3-310 and Attachment 4.19-D of the Medicaid State Plan apply to this rule:

(1) "Non-state governmental entity (NSGE)" means a hospital authority, hospital district, healthcare district, special services district, county, or city.

(2) "Non-state government-owned (NSGO) nursing care facility" means a nursing care facility where an NSGE holds the license and is party to the facility's Medicaid provider contract.

(3) "Eligible nursing care facilities" means facilities that are NSGO nursing facilities, which comply with the requirements described in this rule.

(4) "Public funds" means funds derived from taxes, assessments, levies, investments, governmental operations, and revenue generated by a special services district and other public revenues within the sole and unrestricted control of an NSGE that holds the license and is party to the Medicaid contract of the eligible nursing care facility. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds and may not be derived from an impermissible source, including recycled Medicaid payments, federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations.

(5) "Effective date of the change of ownership" means the issue date of the license for the new owner by the Department of Health and Human Services.

R414-505-3. NF NSGO UPL Payment Program.

The NF NSGO UPL supplemental payment program is governed by Attachment 4.19-D of the Medicaid State Plan.

R414-505-4. Notice of Intent to Participate.

(1) Before an NSGO nursing care facility may receive supplemental payments, the appropriate NSGE must certify certain facts, representations, and assurances regarding program requirements. The NSGE must complete the NF NSGO UPL program notice of participation form prescribed by the Department. The NSGE must email the required application to nf_rates@utah.gov.

(2) The NSGO NF UPL program notice of participation form must be complete and accurate or it will be returned. The Department does not consider incomplete forms as providing notice of intent to participate.

R414-505-5. Requirements to Participate in the NF NSGO UPL Program.

(1)(a) An NSGE must own the nursing care facility.

(b) Before the Medicaid agency initiates a contract, the nursing care facility owner shall provide appropriate legal evidence, as determined by the Medicaid agency, demonstrating an NSGE owns the nursing care facility.

(c) A nursing care facility participating in this supplemental payment program must notify the Office of Financial Services at the email address noted in Section R414-505-4, of changes in ownership that may affect the nursing care facility's continued eligibility within 14 calendar days after the change.

(2) The Medicaid provider enrollment process must be complete.

(3)(a) The NSGE must have an NF NSGO UPL contract in effect, signed by the Department's authorized representative.

(b) The effective date for an NF NSGO UPL contract for a nursing care facility to participate in the NF NSGO UPL supplemental payments must be the latter of the following dates:

(i) the effective date of the change of ownership;

(ii) the email date of the notice of intent to participate as noted in Section R414-505-4; or

(iii) the effective date of the Medicaid provider enrollment.

(4) Once a contract is in effect, the Department shall make payments in accordance with Attachment 4.19-D of the Medicaid State Plan and the NF NSGO UPL contract.

(5)(a) State funding for supplemental payments authorized in this rule is limited to and obtained through intergovernmental transfer (IGT) agreements of public funds or other permissible source-of-seed funding from the NSGE that holds the license and is party to the Medicaid contract of the nursing care facility.

(b) The NSGE shall ensure that the funds provided to the Department for the non-federal share, via IGT, meet the requirements of 42 CFR 433 Subpart B.

R414-505-6. IGT Certification.

(1) With its IGT, using the IGT certification form prescribed by the Department, the NSGE shall specify the dollar amount and certify the source of the IGT funds. The NSGE shall specify on the form, a detailed description of the IGT monies and the legal basis for the monies ability to be used to match federal funds.

(2) Using the IGT annual certification form prescribed by the Department, the NSGE shall submit its annual IGT certification required in Section 26B-3-130 no later than 30 days following the end of the NSGE's fiscal year end date.

KEY: Medicaid
Date of Last Change: November 20, 2023
Notice of Continuation: June 10, 2021
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108