Effective 5/3/2023

Part 3
Administration of Medicaid Programs: Drug Utilization Review and Long Term Care Facility Certification

26B-3-301 Definitions.

As used in this part:

(1) "Appropriate and medically necessary" means, regarding drug prescribing, dispensing, and patient usage, that it is in conformity with the criteria and standards developed in accordance with this part.

(2) "Board" means the Drug Utilization Review Board created in Section 26B-3-302.

(3) "Certified program" means a nursing care facility program with Medicaid certification.

(4) "Compendia" means resources widely accepted by the medical profession in the efficacious use of drugs, including "American Hospital Formulary Service Drug Information," "U.S. Pharmacopeia - Drug Information," "A.M.A. Drug Evaluations," peer-reviewed medical literature, and information provided by manufacturers of drug products.

(5) "Counseling" means the activities conducted by a pharmacist to inform Medicaid recipients about the proper use of drugs, as required by the board under this part.

(6) "Criteria" means those predetermined and explicitly accepted elements used to measure drug use on an ongoing basis in order to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(7) "Drug-disease contraindications" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.

(8) "Drug-interactions" means that two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present, or that leads to interference with the effectiveness of one or any of the drugs.

(9) "Drug Utilization Review" or "DUR" means the program designed to measure and assess, on a retrospective and prospective basis, the proper use of outpatient drugs in the Medicaid program.

(10) "Intervention" means a form of communication utilized by the board with a prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

(11) "Medicaid certification" means the right of a nursing care facility, as a provider of a nursing care facility program, to receive Medicaid reimbursement for a specified number of beds within the facility.

(12)

(a) "Nursing care facility" means the following facilities licensed by the department under Chapter 2, Part 2, Health Care Facility Licensing and Inspection:

(i) skilled nursing facilities;

(ii) intermediate care facilities; and

(iii) an intermediate care facility for people with an intellectual disability.

(b) "Nursing care facility" does not mean a critical access hospital that meets the criteria of 42 U.S.C. Sec. 1395i-4(c)(2) (1998).

(13) "Nursing care facility program" means the personnel, licenses, services, contracts, and all other requirements that shall be met for a nursing care facility to be eligible for Medicaid certification under this part and division rule.

(14) "Overutilization" or "underutilization" means the use of a drug in such quantities that the desired therapeutic goal is not achieved.

(15) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act.
(16) "Physical facility" means the buildings or other physical structures where a nursing care facility program is operated.
(17) "Physician" means a person licensed in this state to practice medicine and surgery under Section 58-67-301 or osteopathic medicine under Section 58-68-301.
(18) "Prospective DUR" means that part of the drug utilization review program that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy problems based on explicit and predetermined criteria and standards.
(19) "Retrospective DUR" means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug use data against predetermined and explicit criteria and standards, on an ongoing basis with professional input.
(20) "Rural county" means a county with a population of less than 50,000, as determined by:
(a) the most recent official census or census estimate of the United States Bureau of the Census; or
(b) the most recent population estimate for the county from the Utah Population Committee, if a population figure for the county is not available under Subsection (20)(a).
(21) "Service area" means the boundaries of the distinct geographic area served by a certified program as determined by the division in accordance with this part and division rule.
(22) "Standards" means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the Medicaid recipient database.
(23) "SURS" means the Surveillance Utilization Review System of the Medicaid program.
(24) "Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.
(25) "Therapeutic duplication" means prescribing and dispensing the same drug or two or more drugs from the same therapeutic class where periods of drug administration overlap and where that practice is not medically indicated.
(26) "Urban county" means a county that is not a rural county.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-302 DUR Board -- Creation and membership -- Expenses.
(1) There is created a 12-member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.
(2)
(a) Except as required by Subsection (2)(b), as terms of current board members expire, the executive director shall appoint each new member or reappointed member to a four-year term.
(b) Notwithstanding the requirements of Subsection (2)(a), the executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.
(c) Persons appointed to the board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms.
(d) The executive director shall provide for geographic balance in representation on the board.
(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.
(4) The membership shall be comprised of the following:

(a) four physicians who are actively engaged in the practice of medicine or osteopathic medicine in this state, to be selected from a list of nominees provided by the Utah Medical Association;
(b) one physician in this state who is actively engaged in academic medicine;
(c) three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the Utah Pharmaceutical Association;
(d) one pharmacist who is actively engaged in academic pharmacy;
(e) one person who shall represent consumers;
(f) one person who shall represent pharmaceutical manufacturers, to be recommended by the Pharmaceutical Manufacturers Association; and
(g) one dentist licensed to practice in this state under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act, who is actively engaged in the practice of dentistry, nominated by the Utah Dental Association.

(5) Physician and pharmacist members of the board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.
(6) The board shall elect a chair from among its members who shall serve a one-year term, and may serve consecutive terms.
(7) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
(a) Section 63A-3-106;
(b) Section 63A-3-107; and
(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Renumbered and Amended by Chapter 306, 2023 General Session

Effective until 10/1/2024

26B-3-303 DUR Board -- Responsibilities.

The board shall:
(1) develop rules necessary to carry out its responsibilities as defined in this part;
(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;
(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:
(a) therapeutic appropriateness;
(b) overutilization or underutilization;
(c) therapeutic duplication;
(d) drug-disease contraindications;
(e) drug-drug interactions;
(f) incorrect drug dosage or duration of drug treatment; and
(g) clinical abuse and misuse;
(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;

(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;
(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;
(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;
(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;
(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;
(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;
(11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec. 712;
(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;
(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63G, Chapter 4, Administrative Procedures Act;
(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:
(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;
(b) potential or actual severe or adverse reactions to drugs;
(c) therapeutic appropriateness;
(d) overutilization or underutilization;
(e) appropriate use of generics;
(f) therapeutic duplication;
(g) drug-disease contraindications;
(h) drug-drug interactions;
(i) incorrect drug dosage and duration of drug treatment;
(j) drug allergy interactions; and
(k) clinical abuse and misuse;
(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:
(a) the name and description of the medication;
(b) administration, form, and duration of therapy;
(c) special directions and precautions for use;
(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;
(e) techniques for self-monitoring drug therapy;
(f) proper storage;
(g) prescription refill information; and
(h) action to be taken in the event of a missed dose; and
(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:

(a) the name, address, age, and gender of the recipient;
(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;
(c) the pharmacist's comments on the individual's drug therapy;
(d) name of prescriber; and
(e) name of drug, dose, duration of therapy, and directions for use.

Renumbered and Amended by Chapter 306, 2023 General Session

Effective 10/1/2024

26B-3-303 DUR Board -- Responsibilities.

The board shall:

(1) develop rules necessary to carry out its responsibilities as defined in this part;
(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;
(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:
(a) therapeutic appropriateness;
(b) overutilization or underutilization;
(c) therapeutic duplication;
(d) drug-disease contraindications;
(e) drug-drug interactions;
(f) incorrect drug dosage or duration of drug treatment; and
(g) clinical abuse and misuse;
(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;
(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;
(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;
(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;
(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;
(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;
(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;
(11) publish the annual Drug Utilization Review report required under 42 C.F.R. Sec. 712;

(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Medical Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;
(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63G, Chapter 4, Administrative Procedures Act;
(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:
(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;
(b) potential or actual severe or adverse reactions to drugs;
(c) therapeutic appropriateness;
(d) overutilization or underutilization;
(e) appropriate use of generics;
(f) therapeutic duplication;
(g) drug-disease contraindications;
(h) drug-drug interactions;
(i) incorrect drug dosage and duration of drug treatment;
(j) drug allergy interactions; and
(k) clinical abuse and misuse;
(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:
(a) the name and description of the medication;
(b) administration, form, and duration of therapy;
(c) special directions and precautions for use;
(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;
(e) techniques for self-monitoring drug therapy;
(f) proper storage;
(g) prescription refill information; and
(h) action to be taken in the event of a missed dose; and
(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:
(a) the name, address, age, and gender of the recipient;
(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;
(c) the pharmacist's comments on the individual's drug therapy;
(d) name of prescriber; and
(e) name of drug, dose, duration of therapy, and directions for use.

26B-3-304 Confidentiality of records.

(1) Information obtained under this part shall be treated as confidential or controlled information under Title 63G, Chapter 2, Government Records Access and Management Act.
(2) The board shall establish procedures ensuring that the information described in Subsection 26B-3-304(16) is held confidential by the pharmacist, being provided to the physician only upon request.

(3) The board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the board. The board may release cumulative nonidentifying information for research purposes.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-305 Drug prior approval program.

(1) A drug prior approval program approved or implemented by the board shall meet the following conditions:
- (a) except as provided in Subsection (2), a drug may not be placed on prior approval for other than medical reasons;
- (b) the board shall hold a public hearing at least 30 days prior to placing a drug on prior approval;
- (c) notwithstanding the provisions of Section 52-4-202, the board shall provide not less than 14 days' notice to the public before holding a public hearing under Subsection (1)(b);
- (d) the board shall consider written and oral comments submitted by interested parties prior to or during the hearing held in accordance with Subsection (1)(b);
- (e) the board shall provide evidence that placing a drug class on prior approval:
  - (i) will not impede quality of recipient care; and
  - (ii) that the drug class is subject to clinical abuse or misuse;
- (f) the board shall reconsider its decision to place a drug on prior approval:
  - (i) no later than nine months after any drug class is placed on prior approval; and
  - (ii) at a public hearing with notice as provided in Subsection (1)(b);
- (g) the program shall provide an approval or denial of a request for prior approval:
  - (i) by either:
    - (A) fax;
    - (B) telephone; or
    - (C) electronic transmission;
  - (ii) at least Monday through Friday, except for state holidays; and
  - (iii) within 24 hours after receipt of the prior approval request;
- (h) the program shall provide for the dispensing of at least a 72-hour supply of the drug on the prior approval program:
  - (i) in an emergency situation; or
  - (ii) on weekends or state holidays;
- (i) the program may be applied to allow acceptable medical use of a drug on prior approval for appropriate off-label indications; and
- (j) before placing a drug class on the prior approval program, the board shall:
  - (i) determine that the requirements of Subsections (1)(a) through (i) have been met; and
  - (ii) by majority vote, place the drug class on prior approval.

(2) The board may, only after complying with Subsections (1)(b) through (j), consider the cost:
- (a) of a drug when placing a drug on the prior approval program; and
- (b) associated with including, or excluding a drug from the prior approval process, including:
  - (i) potential side effects associated with a drug; or
  - (ii) potential hospitalizations or other complications that may occur as a result of a drug's inclusion on the prior approval process.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-306 Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under Sections 26B-3-302 through 26B-3-309.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-307 Retrospective and prospective DUR.

(1) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.
(2) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (3) and (4).
(3) The retrospective DUR program shall be based on guidelines established by the board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to:
  (a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and
  (b) assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:
    (i) therapeutic appropriateness;
    (ii) overutilization or underutilization;
    (iii) therapeutic duplication;
    (iv) drug-disease contraindications;
    (v) drug-drug interactions;
    (vi) incorrect drug dosage or duration of drug treatment; and
    (vii) clinical abuse and misuse.
(4) The prospective DUR program shall be based on guidelines established by the board and shall provide that, before a prescription is filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:
  (a) therapeutic duplication;
  (b) drug-drug interactions;
  (c) incorrect dosage or duration of treatment;
  (d) drug-allergy interactions; and
  (e) clinical abuse or misuse.
(5) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician or physician assistant. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-308 Penalties.

Any person who violates the confidentiality provisions of Sections 26B-3-302 through 26B-3-307 is guilty of a class B misdemeanor.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-309 Immunity.

There is no liability on the part of, and no cause of action of any nature arises against any member of the board, its agents, or employees for any action or omission by them in effecting the provisions of Sections 26B-3-302 through 26B-3-307.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-310 Purpose -- Medicaid certification of nursing care facilities.

(1) The Legislature finds:
  (a) that an oversupply of nursing care facilities in the state adversely affects the state Medicaid program and the health of the people in the state;
  (b) it is in the best interest of the state to prohibit nursing care facilities from receiving Medicaid certification, except as provided by Sections 26B-3-311 through 26B-3-313; and
  (c) it is in the best interest of the state to encourage aging nursing care facilities with Medicaid certification to renovate the nursing care facilities' physical facilities so that the quality of life and clinical services for Medicaid residents are preserved.
(2) Medicaid reimbursement of nursing care facility programs is limited to:
  (a) the number of nursing care facility programs with Medicaid certification as of May 9, 2016; and
  (b) additional nursing care facility programs approved for Medicaid certification under the provisions of Subsections 26B-3-311(5) and (7).
(3) The division may not:
  (a) except as authorized by Section 26B-3-311:
    (i) process initial applications for Medicaid certification or execute provider agreements with nursing care facility programs; or
    (ii) reinstate Medicaid certification for a nursing care facility whose certification expired or was terminated by action of the federal or state government; or
  (b) execute a Medicaid provider agreement with a certified program that moves to a different physical facility, except as authorized by Subsection 26B-3-311(3).
(4) Notwithstanding Section 26B-3-311, beginning May 4, 2021, the division may not approve a new or additional bed in an intermediate care facility for individuals with an intellectual disability for Medicaid certification, unless certification of the bed by the division does not increase the total number in the state of Medicaid-certified beds in intermediate care facilities for individuals with an intellectual disability.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-311 Authorization to renew, transfer, or increase Medicaid certified programs -- Reimbursement methodology.

(1)
  (a) The division may renew Medicaid certification of a certified program if the program, without lapse in service to Medicaid recipients, has its nursing care facility program certified by the division at the same physical facility as long as the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) The division may renew Medicaid certification of a nursing care facility program that is not currently certified if:

(i) since the day on which the program last operated with Medicaid certification:

(A) the physical facility where the program operated has functioned solely and continuously as a nursing care facility; and

(B) the owner of the program has not, under this section or Section 26B-3-313, transferred to another nursing care facility program the license for any of the Medicaid beds in the program; and

(ii) except as provided in Subsection 26B-3-310(4), the number of beds granted renewed Medicaid certification does not exceed the number of beds certified at the time the program last operated with Medicaid certification, excluding a period of time where the program operated with temporary certification under Subsection 26B-3-312(3).

(2)

(a) The division may issue a Medicaid certification for a new nursing care facility program if a current owner of the Medicaid certified program transfers its ownership of the Medicaid certification to the new nursing care facility program and the new nursing care facility program meets all of the following conditions:

(i) the new nursing care facility program operates at the same physical facility as the previous Medicaid certified program;

(ii) the new nursing care facility program gives a written assurance to the director in accordance with Subsection (4);

(iii) the new nursing care facility program receives the Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient; and

(iv) the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) A nursing care facility program that receives Medicaid certification under the provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing care facility program if the new nursing care facility program:

(i) is not owned in whole or in part by the previous nursing care facility program; or

(ii) is not a successor in interest of the previous nursing care facility program.

(3) The division may issue a Medicaid certification to a nursing care facility program that was previously a certified program but now resides in a new or renovated physical facility if the nursing care facility program meets all of the following:

(a) the nursing care facility program met all applicable requirements for Medicaid certification at the time of closure;

(b) the new or renovated physical facility is in the same county or within a five-mile radius of the original physical facility;

(c) the time between which the certified program ceased to operate in the original facility and will begin to operate in the new physical facility is not more than three years, unless:

(i) an emergency is declared by the president of the United States or the governor, affecting the building or renovation of the physical facility;

(ii) the director approves an exception to the three-year requirement for any nursing care facility program within the three-year requirement;

(iii) the provider submits documentation supporting a request for an extension to the director that demonstrates a need for an extension; and

(iv) the exception does not extend for more than two years beyond the three-year requirement;

(d) if Subsection (3)(c) applies, the certified program notifies the department within 90 days after ceasing operations in its original facility, of its intent to retain its Medicaid certification;
(e) the provider gives written assurance to the director in accordance with Subsection (4) that no third party has a legitimate claim to operate a certified program at the previous physical facility; and
(f) the bed capacity in the physical facility has not been expanded unless the director has approved additional beds in accordance with Subsection (5).

(4)
(a) The entity requesting Medicaid certification under Subsections (2) and (3) shall give written assurances satisfactory to the director or the director's designee that:
(i) no third party has a legitimate claim to operate the certified program;
(ii) the requesting entity agrees to defend and indemnify the department against any claims by a third party who may assert a right to operate the certified program; and
(iii) if a third party is found, by final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the physical facility the certified program shall voluntarily comply with Subsection (4)(b).
(b) If a finding is made under the provisions of Subsection (4)(a)(iii):
(i) the certified program shall immediately surrender its Medicaid certification and comply with division rules regarding billing for Medicaid and the provision of services to Medicaid patients; and
(ii) the department shall transfer the surrendered Medicaid certification to the third party who prevailed under Subsection (4)(a)(iii).

(5)
(a) The director may approve additional nursing care facility programs for Medicaid certification, or additional beds for Medicaid certification within an existing nursing care facility program, if a nursing care facility or other interested party requests Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program, and the nursing care facility program or other interested party complies with this section.
(b) Except as provided under Subsection (5)(e), a nursing care facility or other interested party requesting Medicaid certification for a nursing care facility program or additional beds within an existing nursing care facility program under Subsection (5)(a) shall submit to the director:
(i) proof of the following as reasonable evidence that bed capacity provided by Medicaid certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient:
(A) nursing care facility occupancy levels for all existing and proposed facilities will be at least 90% for the next three years;
(B) current nursing care facility occupancy is 90% or more; or
(C) there is no other nursing care facility within a 35-mile radius of the nursing care facility requesting the additional certification; and
(ii) an independent analysis demonstrating that at projected occupancy rates the nursing care facility's after-tax net income is sufficient for the facility to be financially viable.
(c) Any request for additional beds as part of a renovation project are limited to the maximum number of beds allowed in Subsection (7).
(d) The director shall determine whether to issue additional Medicaid certification by considering:
(i) whether bed capacity provided by certified programs within the county or group of counties impacted by the requested additional Medicaid certification is insufficient, based on the information submitted to the director under Subsection (5)(b);

(ii) whether the county or group of counties impacted by the requested additional Medicaid certification is underserved by specialized or unique services that would be provided by the nursing care facility;

(iii) whether any Medicaid certified beds are subject to a claim by a previous certified program that may reopen under the provisions of Subsections (2) and (3);

(iv) how additional bed capacity should be added to the long-term care delivery system to best meet the needs of Medicaid recipients;

(v)

(A) whether the existing certified programs within the county or group of counties have provided services of sufficient quality to merit at least a two-star rating in the Medicare Five-Star Quality Rating System over the previous three-year period; and

(B) information obtained under Subsection (9); and

(vi) subject to Subsection (5)(e), for a state-owned veterans nursing care facility, whether the facility has previously been approved for a Medicaid certified bed increase under this Subsection (5).

(e) For a state-owned veterans nursing care facility that has not previously been approved for a Medicaid certified bed increase under this Subsection (5):

(i) the facility is exempt from the requirements under Subsection (5)(b); and

(ii) the director may approve, for that facility location only, up to five total Medicaid certified beds.

(6) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility property reimbursement methodology to:

(a) only pay that portion of the property component of rates, representing actual bed usage by Medicaid clients as a percentage of the greater of:

(i) actual occupancy; or

(ii)

(A) for a nursing care facility other than a facility described in Subsection (6)(a)(ii)(B), 85% of total bed capacity; or

(B) for a rural nursing care facility, 65% of total bed capacity; and

(b) not allow for increases in reimbursement for property values without major renovation or replacement projects as defined by the department by rule.

(7)

(a) Except as provided in Subsection 26B-3-310(3), if a nursing care facility does not seek Medicaid certification for a bed under Subsections (1) through (6), the department shall, notwithstanding Subsections 26B-3-312(3)(a) and (b), grant Medicaid certification for additional beds in an existing Medicaid certified nursing care facility that has 90 or fewer licensed beds, including Medicaid certified beds, in the facility if:

(i) the nursing care facility program was previously a certified program for all beds but now resides in a new facility or in a facility that underwent major renovations involving major structural changes, with 50% or greater facility square footage design changes, requiring review and approval by the department;

(ii) the nursing care facility meets the quality of care regulations issued by CMS; and

(iii) the total number of additional beds in the facility granted Medicaid certification under this section does not exceed 10% of the number of licensed beds in the facility.

(b) The department may not revoke the Medicaid certification of a bed under this Subsection (7) as long as the provisions of Subsection (7)(a)(ii) are met.

(8)

(a) If a nursing care facility or other interested party indicates in its request for additional Medicaid certification under Subsection (5)(a) that the facility will offer specialized or unique services, but the facility does not offer those services after receiving additional Medicaid certification, the director shall revoke the additional Medicaid certification.

(b) The nursing care facility program shall obtain Medicaid certification for any additional Medicaid beds approved under Subsection (5) or (7) within three years of the date of the director's approval, or the approval is void.

(9)

(a) If the director makes an initial determination that quality standards under Subsection (5)(d)(v) have not been met in a rural county or group of rural counties over the previous three-year period, the director shall, before approving certification of additional Medicaid beds in the rural county or group of counties:

(i) notify the certified program that has not met the quality standards in Subsection (5)(d)(v) that the director intends to certify additional Medicaid beds under the provisions of Subsection (5)(d)(v); and

(ii) consider additional information submitted to the director by the certified program in a rural county that has not met the quality standards under Subsection (5)(d)(v).

(b) The notice under Subsection (9)(a) does not give the certified program that has not met the quality standards under Subsection (5)(d)(v), the right to legally challenge or appeal the director's decision to certify additional Medicaid beds under Subsection (5)(d)(v).

26B-3-312 Appeals of division decision -- Rulemaking authority -- Application of act.

(1) A decision by the director under this part to deny Medicaid certification for a nursing care facility program or to deny additional bed capacity for an existing certified program is subject to review under the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act.

(2) The department shall make rules to administer and enforce Sections 26B-3-310 through 26B-3-313 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3)

(a) In the event the department is at risk for a federal disallowance with regard to a Medicaid recipient being served in a nursing care facility program that is not Medicaid certified, the department may grant temporary Medicaid certification to that facility for up to 24 months.

(b)

(i) The department may extend a temporary Medicaid certification granted to a facility under Subsection (3)(a):

(A) for the number of beds in the nursing care facility occupied by a Medicaid recipient; and

(B) for the period of time during which the Medicaid recipient resides at the facility.

(ii) A temporary Medicaid certification granted under this Subsection (3) is revoked upon:

(A) the discharge of the patient from the facility; or

(B) the patient no longer residing at the facility for any reason.

(c) The department may place conditions on the temporary certification granted under Subsections (3)(a) and (b), such as:

(i) not allowing additional admissions of Medicaid recipients to the program; and

(ii) not paying for the care of the patient after October 1, 2008, with state only dollars.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-313 Authorization to sell or transfer licensed Medicaid beds -- Duties of transferor -- Duties of transferee -- Duties of division.

(1) This section provides a method to transfer or sell the license for a Medicaid bed from a nursing care facility program to another entity that is in addition to the authorization to transfer under Section 26B-3-311.

(2)

(a) A nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds in accordance with Subsection (2)(b) if:

(i) at the time of the transfer, and with respect to the license for the Medicaid bed that will be transferred, the nursing care facility program that will transfer the Medicaid license meets all applicable regulations for Medicaid certification;

(ii) the nursing care facility program gives a written assurance, which is postmarked or has proof of delivery 30 days before the transfer, to the director and to the transferee in accordance with Subsection 26B-3-311(4);

(iii) the nursing care facility program that will transfer the license for a Medicaid bed notifies the division in writing, which is postmarked or has proof of delivery 30 days before the transfer, of:

(A) the number of bed licenses that will be transferred;

(B) the date of the transfer; and

(C) the identity and location of the entity receiving the transferred licenses; and

(iv) if the nursing care facility program for which the license will be transferred or purchased is located in an urban county with a nursing care facility average annual occupancy rate over the previous two years less than or equal to 75%, the nursing care facility program transferring or selling the license demonstrates to the satisfaction of the director that the sale or transfer:

(A) will not result in an excessive number of Medicaid certified beds within the county or group of counties that would be impacted by the transfer or sale; and

(B) best meets the needs of Medicaid recipients.

(b) Except as provided in Subsection (2)(c), a nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds to:

(i) a nursing care facility program that has the same owner or successor in interest of the same owner;

(ii) a nursing care facility program that has a different owner; or

(iii) a related-party nonnursing-care-facility entity that wants to hold one or more of the licenses for a nursing care facility program not yet identified, as long as:

(A) the licenses are subsequently transferred or sold to a nursing care facility program within three years; and

(B) the nursing care facility program notifies the director of the transfer or sale in accordance with Subsection (2)(a)(iii).

(c)

(i) Subject to Subsection (2)(c)(ii), a nursing care facility program may not transfer or sell one or more of its licenses for Medicaid beds to an entity under Subsection (2)(b)(i), (ii), or (iii) that is located in a rural county unless the entity requests, and the director issues, Medicaid certification for the beds under Subsection 26B-3-311(5).

(ii) A veterans nursing care facility that has been approved for a Medicaid certified bed increase under Subsection 26B-3-311(5) may not transfer or sell any of the veterans nursing care facility's Medicaid certified beds.

(3) A nursing care facility program or entity under Subsection (2)(b)(i), (ii), or (iii) that receives or purchases a license for a Medicaid bed under Subsection (2)(b):
(a) may receive a license for a Medicaid bed from more than one nursing care facility program;
(b) shall give the division notice, which is postmarked or has proof of delivery within 14 days of the nursing care facility program or entity seeking Medicaid certification of beds in the nursing care facility program or entity, of the total number of licenses for Medicaid beds that the entity received and who it received the licenses from;
(c) may only seek Medicaid certification for the number of licensed beds in the nursing care facility program equal to the total number of licenses for Medicaid beds received by the entity;
(d) does not have to demonstrate need or seek approval for the Medicaid licensed bed under Subsection 26B-3-311(5), except as provided in Subsections (2)(a)(iv) and (2)(c) ;
(e) shall meet the standards for Medicaid certification other than those in Subsection 26B-3-311(5), including personnel, services, contracts, and licensing of facilities under Chapter 2, Part 2, Health Care Facility Licensing and Inspection; and
(f) shall obtain Medicaid certification for the licensed Medicaid beds within three years of the date of transfer as documented under Subsection (2)(a)(iii)(B).
(4)
(a) When the division receives notice of a transfer of a license for a Medicaid bed under Subsection (2)(a)(iii)(A), the department shall reduce the number of licenses for Medicaid beds at the transferring nursing care facility:
(i) equal to the number of licenses transferred; and
(ii) effective on the date of the transfer as reported under Subsection (2)(a)(iii)(B).
(b) For purposes of Section 26B-3-310, the division shall approve Medicaid certification for the receiving nursing care facility program or entity:
(i) in accordance with the formula established in Subsection (3)(c); and
(ii) if:
(A) the nursing care facility seeks Medicaid certification for the transferred licenses within the time limit required by Subsection (3)(f); and
(B) the nursing care facility program meets other requirements for Medicaid certification under Subsection (3)(e).
(c) A license for a Medicaid bed may not be approved for Medicaid certification without meeting the requirements of Sections 26B-3-310 and 26B-3-311 if:
(i) the license for a Medicaid bed is transferred under this section but the receiving entity does not obtain Medicaid certification for the licensed bed within the time required by Subsection (3)(f); or
(ii) the license for a Medicaid bed is transferred under this section but the license is no longer eligible for Medicaid certification.