DMHF Rules Matrix 1-19-23

Rule Summary	Bulletin Publication	Effective
R414-27 Medicaid Enrollment Process for Nursing Care Facilities (Five-Year Review); The Department will continue this rule because it governs the enrollment of nursing care facilities to receive Medicaid payments after a change of ownership, and outlines the duties of the transferor and transferee following the change.	**1-15-23**	**12-30-22**
R414-516 Nursing Facility Non-State Government-Owned Upper Payment Limit Quality Improvement Program; The Department will continue this rule because it sets forth provisions for non-state government-owned nursing facilities to improve the quality of life for their residents.	**1-15-23**	**12-30-22**
R414-301 Medicaid General Provisions (Five-Year Review); The Department will continue this rule because it defines Medicaid programs, groups and eligibility, spells out member rights and responsibilities in regard to application and enrollment, implements provisions to safeguard member information, allows members to request agency conferences and fair hearings to resolve problems, and implements agency contract provisions to do eligibility determinations and provide fair hearings. The Department will soon file an amendment to this rule to update entity names and roles in relation to its contracts.	**2-1-23**	**1-6-23**
R414-302 Eligibility Requirements (Five-Year Review); The Department will continue this rule because it sets forth eligibility requirements for Medicaid members and applicants that relate to citizenship, residence, child support, institutionalization, identification, applying for other benefits, third-party liability, assignment of rights, enforcement of medical support, and financial responsibility.	**2-1-23**	**1-6-23**
R414-303 Coverage Groups (Five-Year Review); The Department will continue this rule because it sets forth eligibility requirements for Medicaid members and applicants that relate to citizenship, residence, child support, institutionalization, identification, applying for other benefits, third-party liability, assignment of rights, enforcement of medical support, and financial responsibility.	**2-1-23**	**1-6-23**
R414-304 Income and Budgeting (Five-Year Review); The Department will continue this rule because it establishes income-based requirements for categorically and medically needy individuals, including groups covered under the Medicaid Work Incentive Program and the modified adjustment gross income (MAGI)-based methodology. This rule is also needed to continue provisions for income determination during the public health emergency period.	**2-1-23**	**1-6-23**
R414-305 Resources (Five-Year Review); The Department will continue this rule because it establishes resource provisions for categorically and medically needy individuals that include transfers, disregards, trusts and annuities, and how to apply modified adjusted gross income (MAGI)-based methodology.	**2-1-23**	**1-6-23**

R414-306 Program Benefits and Date of Eligibility (Five-Year Review); The Department will continue this rule because it establishes effective dates of eligibility and benefits available to qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, and qualifying individuals. It will also continue this rule because it requires program coordination to inform members of available benefits, refers members to available transportation services, and spells out criteria for supplemental payments to institutionalized individuals.	**2-1-23**	**1-6-23**
R414-308 Application, Eligibility Determinations, Improper Medical Assistance, and Suspension of Benefits (Five-Year Review); The Department will continue this rule because it implements procedures for application, establishes protocol for verifications and exchanges, specifies procedures for eligibility decisions and periods of review, sets forth requirements for change reporting, spells out protocols for case closures and redeterminations, outlines member and agency responsibilities in cases of improper medical coverage, and assures continued coverage through the duration of the public health emergency for individuals who are eligible.	**2-1-23**	**1-6-23**

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

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-27**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Medicaid Enrollment Process for Nursing Care Facilities

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

Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules, and Section 26-18-503 authorizes the Department to grant Medicaid certification to new nursing care facility programs when there is a transfer of ownership.

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

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

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

The Department will continue this rule because it governs the enrollment of nursing care facilities to receive Medicaid payments after a change of ownership, and outlines the duties of the transferor and transferee following the change.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	12/30/2022

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-27. Medicaid Enrollment Process for Nursing Care Facilities.
R414-27-1. Introduction and Authority.

(1) This rule governs the enrollment of nursing care facilities to receive Medicaid payments for services to Medicaid eligible individuals.

(2) This rule outlines the duties of the transferor and transferee following a change of ownership.

(3) This rule is authorized under Sections 26-18-3 and 26-18-5.

R414-27-2. Definitions.

(1) "Change of Ownership" (CHOW) means the owner of a licensed and certified nursing care facility program (transferor) transfers ownership of that program to another entity (transferee).

(2) "Transferor" is the entity or nursing care facility program transferring ownership to another entity.

(3) "Transferee" is the entity receiving ownership of the nursing care facility program from another entity.

(4) "Independent analysis" referred to in Subsection 26-18-503(5)(b) means an analysis performed by independent third-party certified public accountants in accordance with generally accepted accounting principles.

R414-27-3. Medicaid Certification Subsequent to CHOW.

(1) The Division of Medicaid and Health Financing (DMHF) may not process an enrollment application for the transferee until the transferor has voided all claims for services on or after the effective date of the CHOW.

(2) A transferor shall settle any outstanding amounts it owes to Medicaid within 30 days of Medicaid enrollment by the transferee. If the transferor fails to return any outstanding amounts as required in Subsection R414-27-3(2):

(a) The transferor shall be subject to a penalty of the greater of $50 or 5 percent of the outstanding amount;

(b) Interest shall also be accrued at a rate of 12 percent annually on any outstanding amount and shall be accrued beginning on the 31st day following the effective date of the CHOW;

(c) DMHF may waive the imposition of a penalty for good cause.

(3) The transferee shall:

(a) Once a provisional license is issued, submit the following to the DMHF Provider Enrollment team in a timely manner:

(i) A provider enrollment application; and

(ii) A copy of the provisional license.

(b) Be enrolled in Medicaid as a new provider before submitting claims.

(4) If the transferee seeks Medicare certification and the Medicare certification date is different than the issued provisional license or Medicaid enrollment effective begin date, then the Medicaid enrollment date shall be the later of the Medicare certification date or the provisional license date. If the Medicare certification date is later than the issued provisional license date, then the transferor may submit Medicaid claims up to, but not including, the Medicare certification date for the transferee in accordance with all other applicable regulations.

(5) If the transferee seeks Medicare certification, the transferee may be enrolled in Medicaid before becoming Medicare-certified provided the transferee is an approved provider, in accordance with 42 CFR 455, Subpart E.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: December 1, 2017
Notice of Continuation: January 2, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; 26-18-503

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-516**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

General Information

2. Rule catchline:
Nursing Facility Non-State Government-Owned Upper Payment Limit Quality Improvement Program
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26B-1-213 grants the Department the power to adopt, amend, or rescind rules, while Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it sets forth provisions for non-state government-owned nursing facilities to improve the quality of life for their residents.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	12/30/2022
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-516. Nursing Facility Non-State Government-Owned Upper Payment Limit Quality Improvement Program.
R414-516-1. Introduction and Authority.

This rule defines participation requirements for the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program. This rule applies only to nursing facility providers who are part of a contract with the Department to participate in the NF NSGO UPL program. This rule is authorized by Sections 26-1-5 and 26-18-3.

R414-516-2. Definitions.

The definitions in Rule R414-505 apply to this rule. The following definitions also apply.

(1) "Certification and survey provider enhanced reports (CASPER)" means a quality measure report used by the Centers for Medicare and Medicaid Services (CMS) to compare data between nursing facility programs.

(2) "Program" means the Quality Improvement (QI) program within the Nursing Care Facility Non-State Government-Owned Upper Payment Limit (NF NSGO UPL) program.

(3) "Resident" means a Medicaid patient who resides in and receives nursing facility services in a Medicaid-certified nursing facility.

(4) "Seed contract" means a contract between the Division of Medicaid and Health Financing (DMHF) and a non-state government entity to participate in the upper payment limit program.

(5) "State licensing" means the entity assigned to regulate health care facilities.

R414-516-3. Quality Improvement Program Requirements of Participation.

(1) A program is required:

(a) to score better than the national average;

(b) improve from the prior state fiscal year (SFY); or

(c) not receive a state survey deficiency of F, H, I, J, K, or L in six of nine metrics.

(2) The metrics and state survey used for the QI Program are in accordance with the following data:

(a) CASPER percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine;

(b) CASPER percentage of long-stay residents with a urinary tract infection;

(c) CASPER percentage of high-risk long-stay residents with pressure ulcers;

(d) CASPER percentage of long-stay residents experiencing one or more falls with major injury;

(e) CASPER percentage of long-stay residents who lose too much weight;

(f) CASPER percentage of long-stay residents who receive an antipsychotic medication;

(g) CASPER percentage of long-stay residents whose ability to move independently worsens;

(h) adjusted nursing staff hours per resident per day; and

(i) a state survey without a quality of care deficiency of F, H, I, J, K, or L.

(3) If state licensing does not conduct a survey for a program in a given SFY, then the survey requirement described in (1)(i) of this section is removed from consideration, and the facility must meet five of eight metrics.

(4) If more than one survey is completed during the QI SFY, then all surveys are used for the period.

(5) The source of data used to calculate compliance comes from the CMS website, except for data described in Subsection R414-516-3(1)(i), which comes from state licensing. The data that represent the SFY are used for the analysis. Each program provides data to CMS for nursing hours and CASPER. The data is then made available in the subsequent SFY and will be downloaded by DMHF.

(6) DMHF does not require a provider that enters the NF NSGO UPL program for only part of an SFY, based on provider participation start date, to comply with the QI requirements described in Subsection (1) in the first SFY.

R414-516-4. Exceptions and Holdings.

(1) DMHF shall notify a program when it does not meet the requirements of Subsection R414-516-3(1), and place the program on probation during the subsequent SFY.

(2) The program must email to qiupl@utah.gov, a detailed description of why the facility did not comply with the requirements within 30 calendar days of receiving notice, and must send a corrective action plan detailing how the facility will comply in the subsequent SFY.

(3) If the program fails to comply with Subsection R414-516-3(1) for a second consecutive SFY, DMHF shall send the program a notice of failure to meet the requirements and shall remove the program from the seed contract.

(a) The program may submit within 30 days of receiving notice, a written request to remain in the seed contract, which contains evidence showing extraordinary circumstances that reasonably prevented the program from demonstrating compliance. Based on the evidence, DMHF may determine the program has provided sufficient documentation to meet its burden of proof and waive program removal from the seed contract.

(b) Effective the last day of the quarter in which DMHF determines non-compliance, DMHF shall remove the program from the seed contract, and the program may not receive payments for at least 12 months.

(c) If DMHF determines the program has complied with Subsection R414-516-3(1) for an entire subsequent SFY, DMHF shall amend the seed contract and reinstate the program effective the first day of the quarter after the determination is made.

KEY: Medicaid
Date of Last Change: December 29, 2021
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-301**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Medicaid General Provisions

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

Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules. In addition, 42 CFR 431.220 through 431.246 requires the Department to implement agency procedures for fair hearings and hearing rights for Medicaid members.

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

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

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

The Department will continue this rule because it defines Medicaid programs, groups and eligibility, spells out member rights and responsibilities in regard to application and enrollment, implements provisions to safeguard member information, allows members to request agency conferences and fair hearings to resolve problems, and implements agency contract provisions to do eligibility determinations and provide fair hearings. The Department will soon file an amendment to this rule to update entity names and roles in relation to its contracts.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/05/2023

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-301. Medicaid General Provisions.
R414-301-1. Authority and Purpose.

(1) This rule is established under the authority of Section 26-18-3.

(2) The purpose of this rule is to establish general provisions governing eligibility for medical assistance programs and the requirement to exchange information with the Federally Facilitated Marketplace (FFM) to facilitate enrollment in health insurance and eligibility determinations for advance premium tax credits.

R414-301-2. Definitions.

The definitions in Section 26-18-2 apply in this rule. In addition, the following definitions apply in Rules R414-301 through R414-308:

(1) "Aged" means an individual who is 65 years of age or older.

(2) "Agency" means the Department of Health as referenced in incorporated federal materials.

(3) "CHEC" means Child Health Evaluation and Care and is the Utah specific term for the federally mandated program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under the age of 21.

(4) "Cost-of-care" means the amount of income after allowable deductions an individual must pay for their long-term care services either in a medical institution or for home and community- based waiver services.

(5) "Deemed Newborn" means a child who receives one year of continuous eligibility because at the time of the child's birth, the child's mother was a Medicaid recipient or was receiving coverage under the Children's Health Insurance Program (CHIP) in a state that provides deemed newborn coverage to infants born to a CHIP eligible mother.

(6) "Department" means the Department of Health.

(7) "Eligibility Agency" means any state office or outreach location of the Department of Workforce Services (DWS) that accepts and processes applications for medical assistance programs under contract with the Department. The Department of Human Services (DHS) is the eligibility agency under contract with the Department to process applications for children in state custody.

(8) "Federal poverty guideline" means the United States (U.S.) federal poverty measure issued annually by the Department and DHS to determine financial eligibility for certain means-tested federal programs.

(9) "Federally Facilitated Marketplace (FFM) means the entity that individuals can access to enroll in health insurance and apply for assistance from insurance affordability programs such as Advanced Premium Tax Credits, Medicaid and CHIP.

(10) "Medically needy" means medical assistance coverage under the provisions of 42 CFR 435.301 that uses the Basic Maintenance Standard as the income limit for eligibility.

(11) "Modified Adjusted Gross Income (MAGI)" means the income that is determined using the methodology defined in 42 CFR 435.603(e).

(12) "Outreach location" means any site other than a state office where state workers are located to accept applications for medical assistance programs. Locations include sites such as hospitals, clinics, homeless shelters, etc.

(13) "QI" means the Qualifying Individuals program, a Medicare Cost-Sharing program.

(14) "QMB" means Qualified Medicare Beneficiary program, a Medicare Cost-Sharing program.

(15) "Reportable change" means any change in circumstances which could affect a client's eligibility for Medicaid, including the following changes:

(a) the source of income;

(b) gross income of $25 or more;

(c) household size;

(d) residence;

(e) gain of a vehicle;

(f) resources;

(g) total allowable deductions of $25 or more;

(h) marital status, deprivation, or living arrangements;

(i) pregnancy or termination of a pregnancy;

(j) onset of a disabling condition;

(k) change in health insurance coverage including changes in the cost of coverage;

(l) tax filing status;

(m) number of dependents claimed as tax dependents;

(n) earnings of a child; and

(o) student status of a child.

(16) "Resident of a medical institution" means a single individual who is a resident of a medical institution from the month after entry into a medical institution until the month prior to discharge from the institution. Death in a medical institution is not considered a discharge from the institution and does not change the client's status as a resident of the medical institution. Married individuals are residents of an institution in the month of entry into the institution and in the month they leave the institution.

(17) "SLMB" means Specified Low-Income Medicare Beneficiary program, a Medicare Cost-Sharing program.

(18) "Spenddown" means an amount of income in excess of the allowable income standard that must be paid in cash to the eligibility agency or incurred through the medical services not paid by Medicaid or other health insurance coverage, or some combination of these.

(19) "Spouse" means any individual who has been married to an applicant or recipient and has not legally terminated the marriage.

(20) "Verification" means the proof needed to decide whether an individual meets the eligibility criteria to be enrolled in the applicable medical assistance program. Verification may include documents in paper format, electronic records from computer match systems, and collateral contacts with third parties who have information needed to determine the eligibility of the individual.

(21) "Worker" means a state employee who determines eligibility for medical assistance programs.

R414-301-3 Coordination and Agreements with Other Government Agencies.

(1) The Department adopts and incorporates by reference 42 CFR 435.1200(b) and (d) through (f), October 1, 2012 ed.

(2) The Department shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to allow the FFM to screen applications and reviews submitted through the FFM for Medicaid eligibility.

(a) The agreement must provide for the exchange of file data and eligibility status information between the Department and the FFM as required to determine eligibility and enrollment in insurance affordability programs, and eligibility for advance premium tax credits and reduced cost-sharing.

(b) The agreement applies to agencies under contract with the Department to provide eligibility determination services.

(3) The Department may contract with the Department of Workforce Services and the Department of Human Services to do eligibility determinations for one or more medical assistance programs authorized by the Department. The Department is responsible for the administration of medical assistance programs authorized under the Utah Medicaid State Plan, the State Plan for the Utah Children's Health Insurance Program, and various waivers under Title XIX of the Social Security Act.

R414-301-4. Client Rights and Responsibilities.

(1) Anyone may apply or reapply any time for any program. A program subject to periods of closed enrollment will deny applications received during a closed enrollment period.

(2) If someone needs help to apply he may have a friend or family member help, or he may request help from the eligibility agency or outreach staff.

(3) Workers will identify themselves to clients.

(4) Workers will treat clients with courtesy, dignity and respect.

(5) Workers will ask for verification and information clearly and courteously. Workers shall send a written request for verifications.

(6) If a client must be visited after working hours, the eligibility worker will make an appointment.

(7) Workers will not enter a client's home without the client's permission.

(8) Clients must provide requested verifications within the time limits given. The eligibility agency may grant additional time to provide information and verifications upon client request.

(9) Clients have a right to be notified about the decision made on an application or other action taken that affects their eligibility for benefits in accordance with the requirements of 42 CFR 431.210, 42 CFR 431.211, 42 CFR 431.213, and 42 CFR 431.214.

(10) Clients may look at most information about their case.

(11) Anyone may look at the policy manuals located at any eligibility agency office or online. Policy manuals are not available for review at outreach locations or call centers.

(12) Applicants and recipients may request a fair hearing if they disagree with the eligibility agency's decision.

(13) The recipient must repay any understated liability. The recipient is responsible for repayments due to ineligibility including benefits received pending a fair hearing decision. In addition to payments made directly to medical providers, benefits include Medicare or other health insurance premiums, premium payments made in the recipient's behalf to Medicaid health plans and mental health providers even if the recipient does not receive a direct medical service from these entities.

(14) The client must report a reportable change as defined in Subsection R414-301-2(15) to the eligibility agency within ten days of the day the change becomes known.

R414-301-5. Safeguarding Information.

(1) The Department adopts and incorporates by reference 42 CFR 431.300 through 42 CFR 431.306, October 1, 2012 ed. The Department requires compliance with Section 63G-2-101 through Section 63G-2-310.

(2) Workers shall safeguard all information about specific clients.

(3) There are no provisions for taxpayers to see any information from client records.

(4) The director or designee shall decide if a situation is an emergency warranting release of information to someone other than the client. The information may be released only to an agency with comparable rules for safeguarding records. The information released cannot include information obtained through an income match system.

R414-301-6. Complaints and Agency Conferences.

(1) A client may request an agency conference with the eligibility staff or supervisor at the eligibility agency at any time to resolve a problem regarding the client's case. Requests shall be granted at the eligibility agency's discretion. Clients may have an authorized representative or a friend attend the agency conference.

(2) Requesting an agency conference does not prevent a client from also requesting a fair hearing in the event the agency conference does not resolve the client's concerns.

(3) Having an agency conference does not extend the time period in which a client has to request a fair hearing. The client must request a fair hearing according to the provisions in Section R414-301-6, to assure the right to a hearing.

(4) There is no appeal to the decisions made during an agency conference; however, if the client is not satisfied with the results of the agency conference, and makes a timely request for a fair hearing as defined in Section R414-301-7, the client may proceed with the fair hearing process.

(5) The eligibility agency shall provide proper notice if the agency makes any additional adverse changes in the client's eligibility as a result of the agency conference. The client then has a right to request a fair hearing based on the new adverse action.

R414-301-7. Hearings.

(1) The eligibility agency shall provide a fair hearing process for applicants and recipients in accordance with the requirements of 42 CFR 431.220 through 42 CFR 431.246. The eligibility agency shall comply with Title 63G, Chapter 4.

(2) An applicant or recipient must request a hearing in writing or orally at the agency that made the final eligibility decision. A request for a hearing concerning a Medicaid eligibility decision must be made within 90 calendar days of the date of the notice of agency action with which the applicant or recipient disagrees. The request need only include a statement that the applicant or recipient wants to present his case.

(3) Hearings are conducted only at the request of a client or spouse; a minor client's parent; or a guardian or representative of the client.

(4) A recipient who requests a fair hearing concerning a decision about Medicaid eligibility shall receive continued medical assistance benefits pending a hearing decision if the recipient requests a hearing before the effective date of the action or within 15 calendar days of the date on the notice of agency action.

(5) The recipient must repay the continued benefits that he receives pending the hearing decision if the hearing decision upholds the agency action.

(a) A recipient may decline the continued benefits that the Department offers pending a hearing decision by notifying the eligibility agency.

(b) Benefits that the recipient must repay include premiums for Medicare or other health insurance, premiums and fees to managed care and contracted mental health services entities, fee-for-service benefits on behalf of the individual, and medical travel fees or reimbursement to or on behalf of the individual.

(6) The eligibility agency must receive a request for a hearing by the close of business on a business day that is before or on the due date. If the due date is a non-business day, the eligibility agency must receive the request by the close of business on the next business day.

(7) DWS conducts fair hearings for all medical assistance cases except those concerning eligibility for advanced premium tax credits made by the FFM, foster care or subsidized adoption Medicaid. The Department conducts hearings for foster care or subsidized adoption Medicaid cases. In addition, the Department conducts hearings concerning its disability determination decisions. The FFM conducts hearings concerning determinations for advanced premium tax credits.

(8) DWS conducts informal, evidentiary hearings in accordance with Section R986-100-124 through Section R986-100-134, except for the provisions in Subsection R986-100-128(17) and Subsection R986-100-134(5). Instead, the provisions in Subsection R414-301-7(16) concerning the time frame to comply with the DWS decision, and Subsection R414-301-7 (17)(c) concerning continued assistance during a superior agency review conducted by the Department apply respectively.

(9) The Department conducts informal hearings concerning eligibility for foster care or subsidized adoption Medicaid in accordance with Rule R414-1. Pursuant to Section 63G-4-402, within 30 days of the date the Department issues the hearing decision, the applicant or recipient may file a petition for judicial review with the district court.

(10) DWS may not conduct a hearing contesting resource assessment until an institutionalized individual has applied for Medicaid.

(11) An applicant or recipient may designate a person or professional organization to assist in the hearing or act as his representative. An applicant or recipient may have a friend or family member attend the hearing for assistance.

(12) The applicant, recipient or representative can arrange to review case information before the scheduled hearing.

(13) At least one employee from the eligibility agency must attend the hearing. Other employees of the eligibility agency, other state agencies and legal representatives for the eligibility agency may attend as needed.

(14) The DWS Division of Adjudication and Appeals shall mail a written hearing decision to the parties involved in the hearing. The decision shall include the decision, a summary of the facts and the policies or regulations supporting the decision.

(a) The DWS decision shall include information about the right to request a superior agency review from the Department and how to make that request.

(b) The applicant or recipient may appeal the DWS decision to the Department pursuant to Section R410-14-18. The request for agency review must be made in writing and delivered to either DWS or the Department within 30 days of the mailing date of the decision.

(15) The Department, as the single state Medicaid agency, is a party to all fair hearings concerning eligibility for medical assistance programs. The Department conducts appeals and has the right to conduct a superior agency review of medical assistance hearing decisions rendered by DWS.

(16) The DWS hearing decision becomes final 30 days after the decision is sent unless the Department conducts a superior agency review. The DWS hearing decision may be made final in less than 30 days upon agreement of all parties.

(17) The Department conducts a superior agency review when the applicant or recipient appeals the DWS decision or upon its own accord if it disagrees with the DWS decision.

(a) The Department notifies DWS whenever it conducts a superior agency review.

(b) The DWS hearing decision is suspended until the Department issues a final decision and order on agency review.

(c) A recipient receiving continued benefits continues to be eligible for continued benefits pending the superior agency review decision.

(18) The superior agency review is an informal proceeding and shall be conducted in accordance with Section 63G-4-301.

(19) A Department decision and order on agency review becomes final upon issuance.

(20) The eligibility agency takes case action within ten calendar days of the date the decision becomes final.

(21) Pursuant to Section 63G-4-402, within 30 days of the date the decision and order on agency review is issued, the applicant or recipient may file a petition for judicial review with the district court. Failure to appeal a DWS hearing decision to the Department negates this right to a judicial appeal.

(22) Recipients are not entitled to continued benefits pending judicial review by the district court.

KEY: client rights, hearings, Medicaid
Date of Enactment or Last Substantive Amendment: October 1, 2013
Notice of Continuation: January 8, 2018
Authorizing, and Implemented or Interpreted Law: 26-18

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-302**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Eligibility Requirements

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

42 CFR 435 Subpart E sets forth requirements for determining Medicaid eligibility, and Section 26-18-3 requires the Department to implement these requirements through its administrative rules.

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

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

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

The Department will continue this rule because it sets forth eligibility requirements for Medicaid members and applicants that relate to citizenship, residence, child support, institutionalization, identification, applying for other benefits, third-party liability, assignment of rights, enforcement of medical support, and financial responsibility.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/05/2023

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-302. Eligibility Requirements.
R414-302-1. Authority and Purpose.

This rule is authorized by Section 26-1-5 and Section 26-18-3 and establishes eligibility requirements for Medicaid and the Medicare Cost Sharing programs.

R414-302-2. Definitions.

The definitions in Rules R414-1 and R414-301 apply to this rule.

R414-302-3. Citizenship and Alienage.

(1) The Department incorporates by reference 42 CFR 435.406 October 1, 2012 ed., which requires applicants and recipients to be

United States (U.S.) citizens or qualified aliens and to provide verification of their U.S. citizenship or lawful alien status.

(2) The Department elects to cover applicants and recipients who are under 19 years of age and lawfully present as defined in 42 U.S.C. 1396b(v) and 42 U.S.C. 1397gg(e)(1), and referenced in Section S89 of the Utah Medicaid State Plan.

(3) The Department shall decide if a public or private organization no longer exists or is unable to meet an alien's needs. The Department shall base the decision on the evidence submitted to support the claim. The documentation submitted by the alien must be sufficient to prove the claim.

(4) One adult household member must declare the citizenship status of all household members who will receive Medicaid.

(5) A qualified alien, as defined in 8 U.S.C. 1641 who was residing in the U.S. before August 22, 1996, may receive full Medicaid, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), or Qualifying Individuals (QI) services.

(6) A qualified alien, as defined in 8 U.S.C. 1641 newly admitted into the U.S. on or after August 22, 1996, may receive full Medicaid, QMB, SLMB, or QI services after five years have passed from the person's date of entry into the U.S.

(7) The Department accepts as verification of citizenship documents from federally recognized Indian tribes evidencing membership or enrollment in such tribe including those with international borders as required under Section 211(b)(1) of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111 3, or as prescribed by the Secretary.

(8) The Department provides reasonable opportunity for applicants or clients to present satisfactory documentation of citizenship as required under Section 211(b)(2) of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111 3.

(9) The Department considers that an infant born to a mother who is eligible for Medicaid at the time of the infant's birth has provided satisfactory evidence of citizenship. The Department does not require further verification of citizenship for the infant as required under Section 211(b)(3) of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111 3.

(10) The Department adopts and incorporates by reference 42 CFR 435.949 and 42 CFR 435.952, October 1, 2012 ed.

(a) The Department shall verify citizenship and immigration status requirements through the Federal Data Services Hub or through other electronic match systems approved by the Secretary.

(b) If the Department cannot verify citizenship or immigration status through an electronic match system or the electronic data is not reasonably compatible with the client statement, the client must provide verification of citizenship and identity as described in 42 CFR 435.407.

R414-302-4. Utah Residence.

(1) The Department adopts and incorporates by reference 42 CFR 435.403, October 1, 2012 ed. The Department also adopts and incorporates by reference Subsection 1902(b) of the Compilation of the Social Security Laws, in effect May 8, 2013.

(2) The Department considers an individual who establishes state residency to be a resident of the state during periods of temporary absence, if the individual intends to return to the state when the purpose for the temporary absence ends.

R414-302-5. Deprivation of Supports.

(1) The Department adopts and incorporates by reference the definition of "dependent child" found in 42 CFR 435.4, October 1, 2012 ed.

(2) A child who lives with two parents is deprived of support if at least one parent is working less than 100 hours a month.

(3) A child is not considered deprived of support if any of the following situations is true:

(a) The parent is absent because of military service;

(b) The parent is absent for employment, schooling, training or another temporary purpose;

(c) The parent will return to live in the home within 30 days from the date of the application;

(d) The parent is the primary child care provider and care is frequent enough that the child is not deprived of support, care and guidance.

(4) A parent is incapacitated if the parent meets one of the following criteria:

(a) The parent receives SSI;

(b) The parent is recognized as 100% disabled by the Veteran's Administration;

(c) The parent is determined disabled by the State Medicaid Disability Office or the Social Security Administration;

(d) The parent provides written documentation completed by a medical professional engaged in the practice of mental health therapy, which states that the parent is incapacitated and the incapacity is expected to last at least 30 days. The medical report must also state that the incapacity substantially reduces the parent's ability to work or care for the child. Full-time employment, however, nullifies the parent's claim of incapacity. The written documentation must be completed by one of the following medical professionals:

(i) Medical Doctor (MD);

(ii) Doctor of Osteopathy (DO);

(iii) Advanced Practice Registered Nurse (APRN);

(iv) Physician Assistant; or

(v) Mental Health Therapist who is either a psychologist, licensed clinical social worker, certified social worker, marriage and family therapist, professional counselor, MD, DO, or APRN.

R414-302-6. Residents of Institutions.

(1) For purposes of institutions, the definitions in 42 CFR 435.1010 apply.

(2) An individual who resides in a halfway house may receive Medicaid coverage if the halfway house meets the following criteria:

(a) The halfway house allows the individual to work outside the facility;

(b) The halfway house allows the individual to use community facilities at will, such as libraries, grocery stores, recreation areas, or schools; and

(c) The halfway house allows the individual to seek health care treatment in the community to the same extent as other Medicaid enrollees.

(3) The Department does not consider an individual who resides in a temporary shelter for a limited period of time as a resident of an institution.

(4) Individuals who are inmates of public institutions are not eligible for Medicaid coverage. As described in Section R414-308-10, individuals who are incarcerated will not be denied Medicaid eligibility nor will their cases be closed, but their cases will be placed in a suspended status.

(5) Individuals who reside in an institution for mental disease (IMD) are not eligible for Medicaid coverage with the following exceptions:

(a) Individuals 65 years of age or older;

(b) Individuals under 22 years of age who receive inpatient psychiatric services as described in 42 CFR 440.160; and

(c) Individuals who reside in an IMD that is licensed as a Substance Use Disorder (SUD) residential treatment program and are receiving treatment for an SUD.

R414-302-7. Social Security Numbers.

(1) The Department adopts and incorporates by reference 42 CFR 435.910, October 1, 2012 ed., which requires the social security number (SSN) of each applicant or beneficiary, specifies the exceptions to requiring the SSN, and specifies agency verification responsibilities. The Department adopts Section 1137 of the Compilation of the Social Security Laws, in effect May 8, 2013, which is incorporated by reference.

(2) Acceptable proof of an SSN is an electronic match, a social security card, or an official document from the Social Security Administration, which identifies the correct number. Acceptable proof of an application for an SSN is a social security receipt that confirms the individual has applied for an SSN.

(3) The Department requires a new proof of application for an SSN at each recertification if the SSN has not previously been provided.

(4) The Department may assign a unique Medicaid identification number to an applicant or beneficiary who meets one of the exceptions to the requirement to provide an SSN.

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

(1) The Department adopts and incorporates by reference 42 CFR 435.608, October 1, 2012 ed., which requires applicants for and recipients of medical assistance to apply for and take all reasonable steps to receive other possible benefits.

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

(3) Individuals who may be eligible for Medicare Part B benefits must apply for Medicare Part B and, if eligible, become enrolled in Medicare Part B to be eligible for Medicaid. The state pays the applicable monthly premium and cost-sharing expenses for Medicare Part B for individuals who are eligible for both Medicaid and Medicare Part B.

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

R414-302-9. Third Party Liability.

(1) The Department adopts and incorporates by reference 42 CFR 433.138(b), October 1, 2012 ed., on the collection of health insurance information. The Department also adopts and incorporates by reference Section 1915(b) of the Compilation of the Social Security Laws, in effect September 9, 2013.

(2) The Department requires clients to report any changes in third party liability information within 30 days.

(3) The Department considers a client uncooperative if the client knowingly withholds third party liability information without good cause.

(4) The Department shall decide whether employer provided group health insurance would be cost effective for the state to purchase as a benefit of Medicaid.

(5) The Department requires clients residing in selected communities to be enrolled in a Health Maintenance Organization as their primary care provider. The Department shall enroll clients who do not make a selection in a Health Maintenance Organization that the Department selects. The Department shall notify clients of the Health Maintenance Organization that they will be enrolled in and allowed ten days to contact the Department with a different selection. If the client fails to notify the Department to make a different selection within ten days, the enrollment shall become effective for the next benefit month.

R414-302-10. Assignment of Rights and Medical Support Enforcement.

The Department adopts and incorporates by reference 42 CFR 433.145 through 433.148, and 435.610, October 1, 2012 ed., which spell out the assignment of rights to the state to collect from liable third parties and to cooperate in establishing paternity and medical support.

R414-302-11. Financial Responsibility.

(1) The Department adopts and incorporates by reference 42 CFR 435.602(a), October 1, 2012 ed., on the financial responsibility of family members.

(2) The Department shall apply the requirements of 42 CFR 435.603 for all individuals eligible for coverage groups subject to the Modified Adjusted Gross Income (MAGI) methodology.

KEY: state residency, citizenship, third party liability, Medicaid
Date of Last Change: January 1, 2020
Notice of Continuation: January 8, 2018
Authorizing, and Implemented or Interpreted Law: 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-303**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Coverage Groups

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

Subparts B, C and D of 42 CFR 435 set forth requirements and options for mandatory and optional coverage of groups within the Medicaid program. In addition, Section 26-18-3 requires the Department to implement coverage for these individuals by administrative rule.

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

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

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

The Department will continue this rule because it establishes eligibility and coverage for categorically and medically needy individuals, including groups covered under the modified adjustment gross income (MAGI)-based methodology, foster care, adoption, Refugee Medicaid, presumptive eligibility, and the Medicaid Cancer Program. This rule is also needed to continue eligibility and coverage for coronavirus testing during the public health emergency period.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/04/2023

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-303. Coverage Groups.
R414-303-1. Authority and Purpose.

This rule is authorized by Sections 26-1-5 and 26-18-3 and establishes eligibility requirements for Medicaid and the Medicare Cost Sharing programs.

R414-303-2. Definitions.

(1) The definitions in Rules R414-1 and R414-301 apply to this rule. In addition, the Department adopts and incorporates by reference the following definitions as found in 42 CFR 435.4, October 1, 2012 ed.:

(a) "Caretaker relative;"

(b) "Family size;"

(c) "Modified Adjusted Gross Income (MAGI);"

(d) "Pregnant woman."

(2) A dependent child who is deprived of support is defined in Section R414-302-5.

(3) The definition of caretaker relative includes individuals of prior generations as designated by the prefix great, or great-great, etc., and children of first cousins.

(a) To qualify for coverage as a non-parent caretaker relative, the non-parent caretaker relative must assume primary responsibility for the dependent child and the child must live with the non-parent caretaker relative or be temporarily absent.

(b) The spouse of the caretaker relative may also qualify for Medicaid coverage.

R414-303-3. Medicaid for Individuals Who Are Aged, Blind or Disabled for Community and Institutional Coverage Groups.

(1) The Department provides Medicaid coverage to individuals as described in 42 CFR 435.120, 435.122, 435.130 through 435.135, 435.137, 435.138, 435.139, 435.211, 435.232, 435.236, 435.301, 435.320, 435.322, 435.324, 435.340, and 435.350, October 1, 2012 ed., which are adopted and incorporated by reference. The Department provides coverage to individuals as required by 1634(b), (c) and (d), 1902(a)(10)(A)(i)(II), 1902(a)(10)(A)(ii)(X), and 1902(a)(10)(E)(i) through (iv) of Title XIX of the Social Security Act in effect January 1, 2013, which are adopted and incorporated by reference. The Department provides coverage to individuals described in Section 1902(a)(10)(A)(ii)(XIII) of Title XIX of the Social Security Act in effect January 1, 2013, which is adopted and incorporated by reference. Coverage under Section 1902(a)(10)(A)(ii)(XIII) is known as the Medicaid Work Incentive Program.

(2) Proof of disability includes a certification of disability from the State Medicaid Disability Office, Supplemental Security Income (SSI) status, or proof that a disabled client is recognized as disabled by the Social Security Administration (SSA).

(3) An individual can request a disability determination from the State Medicaid Disability Office. The Department adopts and incorporates by reference the disability determination requirements described in 42 CFR 435.541, October 1, 2012 ed., and Social Security's disability requirements for the Supplemental Security Income program as described in 20 CFR 416.901 through 416.998, April 1, 2012 ed., to decide if an individual is disabled. The Department notifies the eligibility agency of its disability decision, which then sends a disability decision notice to the client.

(a) If an individual has earned income, the State Medicaid Disability Office shall review medical information to determine if the client is disabled without regard to whether the earned income exceeds the Substantial Gainful Activity level defined by the Social Security Administration.

(b) If, within the prior 12 months, SSA has determined that the individual is not disabled, the eligibility agency must follow SSA's decision. If the individual is appealing SSA's denial of disability, the State Medicaid Disability Office must follow SSA's decision throughout the appeal process, including the final SSA decision.

(c) If, within the prior 12 months, SSA has determined an individual is not disabled but the individual claims to have become disabled since the SSA decision, the State Medicaid Disability Office shall review current medical information to determine if the client is disabled.

(d) Clients must provide the required medical evidence and cooperate in obtaining any necessary evaluations to establish disability.

(e) Recipients must cooperate in completing continuing disability reviews as required by the State Medicaid Disability Office unless they have a current approval of disability from SSA. Medicaid eligibility as a disabled individual will end if the individual fails to cooperate in a continuing disability review.

(4) If an individual who is denied disability status by the State Medicaid Disability Office requests a fair hearing, the individual may request a reconsideration as part of the fair hearing process. The individual must request the hearing within the time limit defined in Section R414-301-7.

(a) The individual may provide the eligibility agency additional medical evidence for the reconsideration.

(b) The reconsideration may take place before the date the fair hearing is scheduled to take place.

(c) The Department may not delay the individual's fair hearing due to the reconsideration process.

(d) The State Medicaid Disability Office shall notify the individual and the Hearings Office of the reconsideration decision.

(i) If disability status is approved pursuant to the reconsideration, the eligibility agency shall complete the Medicaid eligibility determination for disability Medicaid. The individual may choose whether to pursue or abandon the fair hearing.

(ii) If disability status is denied pursuant to the reconsideration, the fair hearing process will proceed unless the individual chooses to abandon the fair hearing.

(5) If the eligibility agency denies an individual's Medicaid application because the State Medicaid Disability Office or SSA has determined that the individual is not disabled and that determination is later reversed on appeal, the eligibility agency determines the individual's eligibility back to the application that gave rise to the appeal. The individual must meet all other eligibility criteria for such past months.

(a) Eligibility cannot begin any earlier than the month of disability onset or three months before the month of application subject to the requirements defined in Section R414-306-4, whichever is later.

(b) If the individual is not receiving medical assistance at the time a successful appeal decision is made, the individual must contact the eligibility agency to request the Disability Medicaid coverage.

(c) The individual must provide any verification the eligibility agency needs to determine eligibility for past and current months for which the individual is requesting medical assistance.

(d) If an individual is determined eligible for past or current months, but must pay a spenddown or Medicaid Work Incentive (MWI) premium for one or more months to receive coverage, the spenddown or MWI premium must be met before Medicaid coverage

may be provided for those months.

(6) The age requirement for Aged Medicaid is 65 years of age.

(7) For children described in Section 1902(a)(10)(A)(i)(II) of the Social Security Act in effect January 1, 2013, the eligibility agency shall conduct periodic redeterminations to assure that the child continues to meet the SSI eligibility criteria as required by such section.

(8) Coverage for qualifying individuals described in Section 1902(a)(10)(E)(iv) of Title XIX of the Social Security Act in effect January 1, 2013, is limited to the amount of funds allocated under Section 1933 of Title XIX of the Social Security Act in effect January 1, 2013, for a given year, or as subsequently authorized by Congress under the American Taxpayer Relief Act, Pub. L. No. 112 240, signed into law on January 2, 2013. The eligibility agency shall deny coverage to applicants when the uncommitted allocated funds are insufficient to provide such coverage.

(9) To determine eligibility under Section 1902(a)(10)(A)(ii)(XIII), if the countable income of the individual and the individual's family does not exceed 250% of the federal poverty guideline for the applicable family size, the eligibility agency shall disregard an amount of earned and unearned income of the individual, the individual's spouse, and a minor individual's parents that equals the difference between the total income and the Supplemental Security Income maximum benefit rate payable.

(10) The eligibility agency shall require individuals eligible under Section 1902(a)(10)(A)(ii)(XIII) to apply for cost-effective health insurance that is available to them.

R414-303-4. Medicaid for Parents and Caretaker Relatives, Pregnant Women, Children, Adults, and Individuals Infected with Tuberculosis Using MAGI Methodology.

(1) The Department provides Medicaid coverage to individuals who are eligible as described in 42 CFR 435.110, 435.116, 435.118, and 435.139, and 42 U.S.C. 1396a(a)(10)(A)(ii)(XII). The Department uses the MAGI methodology defined in Section R414-304-5 to determine household composition and countable income for these individuals.

(2) To qualify for coverage, a parent or other caretaker relative must have a dependent child living with the parent or other caretaker relative.

(3) The Department provides Medicaid coverage to parents and other caretaker relatives as required in 42 CFR 435.110, whose countable income is equal to or below the applicable income standard for the individual's family size. For a family that exceeds 16 persons, the Department adds $62 to the income standard for each family member. The income standards are as follows:

TABLE

Family Size	Income Standard
1	$438
2	$544
3	$678
4	$797
5	$912
6	$1,012
7	$1,072
8	$1,132
9	$1,196
10	$1,257
11	$1,320
12	$1,382
13	$1,443
14	$1,505
15	$1,569
16	$1,630

(4) The Department provides Medicaid coverage to children who are zero through five years of age as required in 42 CFR 435.118, whose countable income is equal to or below 139% of the FPL.

(5) The Department provides Medicaid coverage to children who are six through 18 years of age as required in 42 CFR 435.118, whose countable income is equal to or below 133% of the FPL.

(6) The Department provides Medicaid coverage to pregnant women as required in 42 CFR 435.116.

(a) The Department elects the income limit of 139% of the FPL to determine a pregnant woman's eligibility for Medicaid.

(b) An individual, as defined in Subsection R414-302-3(2), may only receive coverage through the end of the month in which the individual turns 19 years old.

(7) The Department provides Medicaid coverage to an infant until the infant turns one-year old when born to a woman eligible for Utah Medicaid on the date of the delivery of the infant, in compliance with Sec. 113(b)(1), Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111 3. The infant does not have to remain in the birth mother's home and the birth mother does not have to continue to be eligible for Medicaid. The infant must continue to be a Utah resident to receive coverage.

(8) The Department provides Medicaid coverage to an individual who is infected with tuberculosis and who does not qualify for a

mandatory Medicaid coverage group. The individual's income cannot exceed the amount of earned income an individual, or if married, a couple, can have to qualify for Supplemental Security Income.

R414-303-5. Medicaid for Parents and Caretaker Relatives, Pregnant Women, and Children Under Non-MAGI-Based Community and Institutional Coverage Groups.

(1) The Department provides Medicaid coverage to individuals who are eligible as described in 42 CFR 435.117, 435.139, 435.170 and 435.301 through 435.310, October 1, 2012 ed. and Title XIX of the Social Security Act Sections 1902(e)(1), (4), (5), (6), (7) in effect January 1, 2013, which are adopted and incorporated by reference.

(2) To qualify for coverage as a medically needy parent or other caretaker relative, the parent or caretaker relative must have a dependent child living with the parent or other caretaker relative.

(a) The parent or other caretaker relative must be determined ineligible for the MAGI-based Parent and Caretaker Relative coverage group.

(b) The parent or other caretaker relative must not have resources in excess of the medically needy resource limit defined in Section R414-305-5.

(3) The income and resources of the non-parent caretaker relative are not counted to determine medically needy eligibility for the dependent child.

(4) To qualify for Child Medically Needy coverage, the dependent child does not have to be deprived of support and does not have to live with a parent or other caretaker relative.

(5) If a child receiving SSI elects to receive Medically-Needy Child Medicaid, the child's SSI income shall be counted with other household income.

(6) The eligibility agency shall determine the countable income of the non-parent caretaker relative and spouse in accordance with Section R414-304-6 and Section R414-304-8.

(a) Countable earned and unearned income of the non-parent caretaker relative and spouse is divided by the number of family members living in the household.

(b) The eligibility agency counts the income attributed to the caretaker relative, and the spouse if the spouse is included in the coverage, to determine eligibility.

(c) The eligibility agency does not count other family members in the non-parent caretaker relative's household to determine the applicable income limit.

(d) The household size includes the caretaker relative and the spouse if the spouse also wants medical coverage.

(7) An American Indian child in a boarding school and a child in a school for the deaf and blind are considered temporarily absent from the household.

(8) An individual who is pregnant, and under 19 years of age as described in Subsection R414-302-3(2), may only receive coverage through the end of the month in which the individual turns 19 years old.

R414-303-6. 12-Month Transitional Medicaid.

The Department shall provide 12 months of extended medical assistance as set forth in 42 U.S.C. 1396r-6, when the parent or caretaker relative is eligible and enrolled in Medicaid as defined in 42 CFR 435.110, and loses eligibility as described in Subsection 1931(c)(2) of the Social Security Act.

(1) A pregnant woman who is eligible and enrolled in Medicaid as defined in 42 CFR 435.116, and who meets the income limit defined in 42 CFR 435.110 for three of the prior six months, is eligible to receive 12-month Transitional Medicaid.

(2) Children who live with the parent are eligible to receive Transitional Medicaid.

R414-303-7. Four-Month Transitional Medicaid.

(1) The Department provides coverage to individuals as described in 42 CFR 435.115. This coverage group is known as the 4 Month Extended program.

(a) A pregnant woman who is eligible and enrolled in Medicaid as defined in 42 CFR 435.116, and who meets the income limit defined in 42 CFR 435.110 for three of the prior six months, is eligible to receive four-month extended coverage.

(b) Changes in household composition do not affect eligibility for the four-month extension period. Newborn babies are considered household members even if they are not born the month the household became ineligible for Medicaid. New members added to the case will lose eligibility when the household loses eligibility. Assistance shall be terminated for household members who leave the household.

R414-303-8. Former Foster Care and Independent Foster Care Individuals.

(1) The Department provides coverage to individuals as described in 42 CFR 435.150. The coverage group is known as the Former Foster Care Individuals program.

(2) When funds are available, the Department elects to cover individuals who are under 21 years of age as described in 42 CFR 435.226. The coverage group is known as the Foster Care Independent Living program.

(3) The Department elects to cover an individual under the responsibility of any state or tribe at the time the individual turns 18 years of age, and was enrolled in Medicaid or the 1115 demonstration project at any time during the foster care period in which the individual turned 18.

(4) There is no income or asset test for eligibility under the Former Foster Care or the Foster Care Independent Living programs.

R414-303-9. Foster Care, Subsidized Adoptions, and Kinship Guardianship Children.

(1) The Department provides coverage to foster care, subsidized adoption, and kinship guardianship individuals as described in 42 CFR 435.145.

(2) The Department elects to cover individuals under a state adoption agreement as defined in 42 CFR 435.227.

(3) The Department of Human Services determines eligibility for Foster Care, Subsidized Adoption, and Kinship Guardianship Medicaid.

R414-303-10. Refugee Medicaid.

(1) The Department adopts and incorporates by reference 45 CFR 400.90 through 400.107 and 45 CFR, Part 401, October 1, 2012 ed., relating to refugee medical assistance.

(2) Child support enforcement rules do not apply.

(3) The sponsor's income and resources are not counted. In-kind service or shelter provided by the sponsor is not counted.

(4) Cash assistance payments received by a refugee from a resettlement agency are not counted.

(5) Refugees may qualify for medical assistance for eight months after entry into the United States.

R414-303-11. Presumptive Eligibility for Medicaid.

(1) The definitions found in 42 CFR 435.1101, and the provisions for presumptive eligibility found in 42 CFR 435.1103 and 42 CFR 435.1110, apply to this section.

(2) The following definitions also apply to this section:

(a) "covered provider" means a provider whom the Department determines is qualified to determine presumptive eligibility for a pregnant woman, and who meets the criteria defined in Subsection 1920(b)(2) of the Social Security Act. Covered provider also means a hospital that elects to be a qualified entity under a memorandum of agreement with the Department;

(b) "presumptive eligibility" means a period of eligibility for medical services, based on an individual's self-declaration of meeting eligibility criteria.

(3) The Department shall provide coverage to a pregnant woman during a period of presumptive eligibility if a covered provider determines, based on preliminary information, that the woman:

(a) is pregnant;

(b) meets citizenship or alien status criteria as defined in Section R414-302-3;

(c) has household income that does not exceed 139% of the federal poverty guideline applicable to her declared household size; and

(d) is not already covered by Medicaid or the Children's Health Insurance Program (CHIP).

(4) A pregnant woman may only receive medical assistance during one presumptive eligibility period for any single term of pregnancy.

(5) A child born to a woman who is only presumptively eligible at the time of the infant's birth is not eligible for the one year of continued coverage defined in Subsection 1902(e)(4) of the Social Security Act. If the mother applies for Medicaid after the birth and is determined eligible back to the date of the infant's birth, the infant is then eligible for the one year of continued coverage under Subsection 1902(e)(4) of the Social Security Act. If the mother is not eligible, the eligibility agency shall determine whether the infant is eligible under other Medicaid programs.

(6) A child determined presumptively eligible who is under 19 years of age may receive presumptive eligibility only through the end of the month after the presumptive determination date, or until the end of the month in which the child turns 19 years of age, whichever occurs first.

(7) An individual determined presumptively eligible for former foster care children coverage may receive presumptive eligibility only through the end of the month after the presumptive determination date, or until the end of the month in which the individual turns 26 years of age, whichever occurs first.

(8) An individual determined presumptively eligible for adult coverage may receive presumptive eligibility through whichever of the following occurs first:

(a) through the end of the month following the month of the presumptive determination;

(b) through the end of the month in which the individual turns 65 years of age; or

(c) until the eligibility agency makes a determination for ongoing medical assistance.

(9) The Department shall limit the coverage groups for which a hospital may make a presumptive eligibility decision to the groups described in 42 CFR 435.110, 435.116, 435.118, 435.150, and Rule R414-312.

(10) A hospital must enter into a memorandum of agreement with the Department to be a qualified entity and receive training on policy and procedures.

(11) The hospital shall cooperate with the Department for audit and quality control reviews on presumptive eligibility determinations the hospital makes. The Department may terminate the agreement with the hospital if the hospital does not meet standards and quality requirements set by the Department.

(12) A covered provider may not count the following as income:

(a) veteran's administration payments;

(b) child support payments; or

(c) educational grants, loans, scholarships, fellowships, or gifts that a client uses to pay for education.

(13) An individual found presumptively eligible for one of the following coverage groups may only receive one presumptive eligibility period in a calendar year:

(a) parents or caretaker relatives;
(b) children under 19 years of age;
(c) former foster care children;
(d) individuals with breast or cervical cancer; and
(e) adult expansion.

(14) A covered provider shall utilize the Department's electronic portal to make presumptive eligibility determinations. The eligibility agency may only determine regular medical assistance if the provider submits a paper application.

R414-303-12. Medicaid Cancer Program.

(1) The Department shall provide coverage to individuals described in Section 1902(a)(10)(A)(ii)(XVIII) of the Social Security Act in effect January 1, 2013, which the Department adopts and incorporates by reference. This coverage shall be referred to as the Medicaid Cancer Program.

(2) The Department provides Medicaid eligibility for services under this program to individuals who are screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and are in need of treatment.

(3) An individual who is covered for treatment of breast or cervical cancer under a group health plan or other health insurance coverage defined by the Health Insurance Portability and Accountability Act (HIPAA) of Section 2701 (c) of the Public Health Service Act, is not eligible for coverage under the program. If the individual has insurance coverage but is subject to a pre-existing condition period that prevents the receipt of treatment for breast or cervical cancer or precancerous condition, the individual is considered to not have other health insurance coverage until the pre-existing condition period ends at which time eligibility for the program ends.

(4) An individual who is eligible for Medicaid under any mandatory categorically needy eligibility group, or any optional categorically needy or medically needy program that does not require a spenddown or a premium, is not eligible for coverage under the program.

(5) An individual must be under 65 years of age to enroll in the program.

(6) Coverage for the treatment of precancerous conditions is limited to two calendar months after the month benefits are made effective.

(7) Coverage for an individual with breast or cervical cancer under Section 1902(a)(10)(A)(ii)(XVIII) ends when treatment is no longer needed for the breast or cervical cancer. At each eligibility review, eligibility workers determine whether treatment is still needed based on the doctor's statement or report.

R414-303-13. Coronavirus (COVID-19) Testing Coverage.

(1) The Department provides coverage to individuals described in Subsection 6004(a)(3) of the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116 127. This coverage shall be referred to as COVID-19 Testing Coverage.

(2) This coverage may be effective no earlier than March 18, 2020, and extends through the end of the public health emergency period and any extensions as defined in Subsection 1135(g)(1)(B) of the Social Security Act.

(3) An individual must meet citizenship or alien status criteria as defined in Section R414-302-3.

(4) An individual must meet residency requirements as defined in Section R414-302-4.

(5) An individual must meet the definition of an uninsured individual as defined in Subsection 1902(ss) of the Social Security Act, and added through Section 6004 of FFCRA, Pub. L. No. 116 127.

(6) An individual receives a limited package of services related to COVID-19 as defined in Subsection 6004(a)(3)(A)(ii) under FFCRA, Pub. L. No. 116 127.

KEY: MAGI-based, coverage groups, former foster care youth, presumptive eligibility
Date of Enactment or Last Substantive Amendment: March 26, 2021
Notice of Continuation: January 8, 2018
Authorizing, and Implemented or Interpreted Law: 26-18-3; 26-1-5

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-304**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Income and Budgeting

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

Subpart G of 42 CFR 435 sets forth general financial eligibility requirements and options for eligibility determinations. In addition, Section 26-18-3 requires the Department to implement these requirements and options by administrative rule.

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

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

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

The Department will continue this rule because it establishes income-based requirements for categorically and medically needy individuals, including groups covered under the Medicaid Work Incentive Program and the modified adjustment gross income (MAGI)-based methodology. This rule is also needed to continue provisions for income determination during the public health emergency period.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/04/2023

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-304. Income and Budgeting.
R414-304-1. Authority and Purpose.

(1) This rule is established under the authority of Section 26-18-3.

(2) The purpose of this rule is to establish the income eligibility criteria for determining eligibility for medical assistance programs.

R414-304-2. Definitions.

(1) The definitions in Rule R414-1, Rule R414-301, and Rule R414-303 apply to this rule. In addition:

(a) "Aid to Families with Dependent Children" (AFDC) means a State Plan for aid that was in effect on June 16, 1996.

(b) "Allocation for a spouse" means an amount of income that is the difference between the Social Security Income (SSI) federal

benefit rate for a couple minus the federal benefit rate for an individual.

(c) "Basic maintenance standard" or "BMS" means the income level for eligibility for Medicaid coverage of the medically needy based on the number of family members who are counted in the household size.

(d) "Benefit month" means a month or any portion of a month for which an individual is eligible for medical assistance.

(e) "Best estimate" means that income is calculated for the upcoming certification period based on current information about income being received, expected income deductions, and household size.

(f) "Deeming" or "deemed" means a process of counting income from a spouse or a parent, or the sponsor of a qualified alien, to decide what amount of income after certain allowable deductions, if any, must be considered income to the applicant or recipient.

(g) "Eligible spouse" means the member of a married couple who is either aged, blind or disabled.

(h) "Factoring" means the eligibility agency calculates the monthly income or income deductions by prorating income to account for months when an individual receives a fifth payment when paid weekly, or a third paycheck with paid every other week. Weekly income is factored by multiplying the weekly income amount by 4.3 to obtain a monthly amount. Income paid every other week is factored by multiplying the bi-weekly income by 2.15 to obtain a monthly amount.

(i) "Family Medicaid" means medical assistance for families caring for dependent children and is a general term used to refer to Medicaid coverage for medically needy parents, caretaker relatives, pregnant women, and children.

(j) "Family member" means a son, daughter, parent, or sibling of the client or the client's spouse, the spouse of the client, and the parents of a dependent child.

(k) "Full-time employment" means an average of 100 or more hours of work a month or an average of 23 hours a week.

(l) "Full-time student" means a person enrolled for the number of hours defined by the particular institution as fulfilling full-time requirements.

(m) "Income annualizing" means using total income earned during one or more past years, or a shorter applicable time period, and anticipating any future changes, to estimate the average annual income. That estimated annual income is then divided by 12 to determine the household's average monthly income.

(n) "Income averaging" means using a history of past income and expected changes, and averaging it over a determined period of time that is representative of future monthly income.

(o) "Income anticipating" means using current facts regarding rate of pay and number of working hours, and reasonably expected future income changes, to anticipate future monthly income.

(p) "In-kind support donor" means an individual who provides food or shelter without receiving full market value compensation in return.

(q) "Prospective budgeting" is the process of calculating income and determining eligibility and spenddown for future months based on the best estimate of income, deductions, and household size.

(r) "School attendance" means enrollment in a public or private elementary or secondary school, a university or college, vocational or technical school or the Job Corps, for the express purpose of gaining skills that lead to gainful employment.

(s) "Presumed maximum value" means the allowed maximum amount an individual is charged for the receipt of food and shelter. This amount will not exceed one-third of the SSI federal benefit rate plus $20.

(t) "Temporarily absent" means a member of a household is living away from the home for a period of time but intends to return to the home when the reason for the temporary absence is accomplished. Reasons for a temporary absence may include an absence for the purpose of education, medical care, visits, military service, temporary religious service or other volunteer service such as the Peace Corps.

R414-304-3. Aged, Blind and Disabled Non-Institutional and Institutional Medicaid Unearned Income Provisions.

(1) The Department adopts and incorporates by reference 42 CFR 435.811 and 435.831, October 1, 2012 ed., and 20 CFR 416.1102, 416.1103, 416.1120 through 416.1124, 416.1140 through 416.1148, 416.1150, 416.1151, 416.1157, 416.1163 through 416.1166, and Appendix to Subpart K of 416, April 1, 2012 ed. The Department also adopts and incorporates by reference Subsections 404(h)(4) and 1612(b)(24) and (25) of the Compilation of the Social Security Laws in effect January 1, 2013, to determine income and income deductions for Medicaid eligibility. The Department may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) The eligibility agency may not count Veterans Administration (VA) payments for aid and attendance or the portion of a VA payment that an individual receives because of unusual medical expenses. Other VA income based on need is countable income, but is not subject to the $20 general income disregard.

(3) The eligibility agency may only count as income the portion of a VA check to which the individual is legally entitled.

(4) The eligibility agency may not count as income Social Security Administration (SSA) reimbursements of Medicare premiums.

(5) The eligibility agency may not count as income the value of special circumstance items if the items are paid for by donors.

(6) For aged, blind and disabled Medicaid, the eligibility agency shall count as income two-thirds of current child support that an individual receives in a month for the disabled child. It does not matter if the payments are voluntary or court-ordered. It does not matter if the child support is received in cash or in-kind. If there is more than one child for whom the payment is made, the amount is divided equally among the children unless a court order indicates a different division.

(7) The eligibility agency shall count as income of the child, child support payments received from a parent or guardian for past months or years.

(8) The agency shall use countable income of the parent to determine the amount of income that will be deemed from the parent to the child to determine the child's eligibility.

(9) For aged, blind and disabled Institutional Medicaid, court-ordered child support payments collected by the Office of Recovery

Services (ORS) for a child who resides out-of-home in a Medicaid 24-hour care facility are not counted as income to the child. If ORS allows the parent to retain up to the amount of the personal needs allowance for the child's personal needs, that amount is counted as income for the child. All other current child support payments received by the child or guardian that are not subject to collection by ORS count as unearned income to the child.

(10) The eligibility agency shall count as unearned income the interest earned from a sales contract on either or both the lump sum and installment payments when the interest is received or made available to the client.

(11) If the client, or the client and spouse do not live with an in-kind support donor, in-kind support and maintenance is the lesser of the value or the presumed maximum value of food or shelter received. If the client, or the client and spouse live with an in-kind support donor and do not pay a prorated share of household operating expenses, in-kind support and maintenance is the difference between the prorated share of household operating expenses and the amount the client, or the client and spouse actually pay, or the presumed maximum value, whichever is less.

(12) Payments under a contract that provide for payments at set intervals or after completion of the contract period are not lump sum payments. The payments are subject to regular income counting rules. Retroactive payments from SSI and SSA reimbursements of Medicare premiums are not lump sum payments.

(13) The eligibility agency may not count as income educational loans, grants, and scholarships received from Title IV programs of the Higher Education Act or from Bureau of Indian Affairs educational programs, and may not count any other grants, scholarships, fellowships, or gifts that a client uses to pay for education. The eligibility agency shall count as income, in the month that the client receives them, any amount of grants, scholarships, fellowships, or gifts that the client uses to pay for non-educational expenses. Allowable educational expenses include:

(a) tuition;

(b) fees;

(c) books;

(d) equipment;

(e) special clothing needed for classes;

(f) travel to and from school at a rate of 21 cents a mile, unless the grant identifies a larger amount; and

(g) child care necessary for school attendance.

(14) The eligibility agency may not count as income, payments from a qualified long-term care insurance partnership plan as defined in 42 U.S.C. 1396p(b)(1)(C)(iii), paid directly to a long-term care provider or collected by the Office of Recovery Services as a third-party liability source.

(15) Except for an individual eligible for the Medicaid Work Incentive (MWI) program, the following provisions apply to non-institutional medical assistance:

(a) For aged, blind and disabled Medicaid, the eligibility agency may not count income of a spouse or a parent to determine Medicaid eligibility of a person who receives SSI or meets 1619(b) criteria. SSI recipients and 1619(b) status individuals who meet all other Medicaid eligibility factors are eligible for Medicaid without spending down.

(b) If an ineligible spouse of an aged, blind or disabled person has more income after deductions than the allocation for a spouse, the eligibility agency shall deem the spouse's income to the aged, blind or disabled spouse to determine eligibility.

(c) The eligibility agency shall determine household size and whose income counts for aged, blind and disabled Medicaid as described below.

(i) If only one spouse is aged, blind or disabled:

(A) The eligibility agency shall deem income of the ineligible spouse to the eligible spouse when that income exceeds the allocation for a spouse. The eligibility agency shall compare the combined income to 100% of the federal poverty guideline for a two-person household. If the combined income exceeds that amount, the eligibility agency shall compare the combined income, after allowable deductions, to the BMS for two to calculate the spenddown.

(B) If the ineligible spouse's income does not exceed the allocation for a spouse, the eligibility agency may not count the ineligible spouse's income and may not include the ineligible spouse in the household size. Only the eligible spouse's income is compared to 100% of the federal poverty guideline for one. If the income exceeds that amount, it is compared, after allowable deductions, to the BMS for one to calculate the spenddown.

(ii) If both spouses are either aged, blind or disabled, the eligibility agency shall combine the income of both spouses and compare to 100% of the federal poverty guideline for a two-person household. SSI income is not counted.

(A) If the combined income exceeds that amount and one spouse receives SSI, the eligibility agency may only compare the income of the non-SSI spouse, after allowable deductions, to the BMS for a one-person household to calculate the spenddown.

(B) If neither spouse receives SSI and their combined income exceeds 100% of the federal poverty guideline, the eligibility agency shall compare the income of both spouses, after allowable deductions, to the BMS for a two-person household to calculate the spenddown.

(C) If neither spouse receives SSI and only one spouse will be covered under the applicable program, the eligibility agency shall deem income of the non-covered spouse to the covered spouse when that income exceeds the spousal allocation. If the non-covered spouse's income does not exceed the spousal allocation, the eligibility agency may only count the covered spouse's income. In both cases, the countable income is compared to 100% of the two-person poverty guideline. If the countable income exceeds the limit, the eligibility agency shall compare the income, after allowable deductions, to the BMS.

(I) If the non-covered spouse has income to deem to the covered spouse, the eligibility agency shall compare the countable income, after allowable deductions, to a two-person BMS to calculate a spenddown.

(II) If the non-covered spouse does not have income to deem to the covered spouse, the eligibility agency may only compare the

covered spouse's income, after allowable deductions, to a one-person BMS to calculate the spenddown.

(iii) In determining eligibility under (c) for an aged or disabled person whose spouse is blind, both spouses' income is combined.

(A) If the combined income after allowable deductions is under 100% of the federal poverty guideline, the aged or disabled spouse will be eligible under the 100% poverty group defined in 1902(a)(10)(A)(ii) of the Social Security Act, and the blind spouse is eligible without a spenddown under the medically needy group defined in 42 CFR 435.301.

(B) If the combined income after allowable deductions is over 100% of poverty, both spouses are eligible with a spenddown under the medically needy group defined in 42 CFR 435.301.

(iv) If one spouse is disabled and working, the other is aged, blind or disabled and not working, and neither spouse is an SSI recipient nor a 1619(b) eligible individual, the working disabled spouse may choose to receive coverage under the MWI program. If both spouses want coverage, however, the eligibility agency shall first determine eligibility for them as a couple. If a spenddown is owed for them as a couple, they must meet the spenddown to receive coverage for both of them.

(d) Except when determining countable income for the 100% poverty-related Aged and Disabled Medicaid programs, the eligibility agency shall not deem income from a spouse who meets 1619(b) protected group criteria.

(e) The eligibility agency shall determine household size and whose income counts for QMB, SLMB, and QI assistance as described below:

(i) If both spouses receive Part A Medicare and both want coverage, the eligibility agency shall combine income of both spouses and compare it to the applicable percentage of the poverty guideline for a two-person household.

(ii) If one spouse receives Part A Medicare and the other spouse is aged, blind or disabled and does not receive Part A Medicare or does not want coverage, then the eligibility agency shall deem income of the ineligible spouse to the eligible spouse when that income exceeds the allocation for a spouse. If the income of the ineligible spouse does not exceed the allocation for a spouse, then only the income of the eligible spouse is counted. In both cases, the eligibility agency shall compare the countable income to the applicable percentage of the federal poverty guideline for a two-person household.

(iii) If one spouse receives Part A Medicare and the other spouse is not aged, blind or disabled, the eligibility agency shall deem income of the ineligible spouse to the eligible spouse when that income exceeds the allocation for a spouse. The agency shall combine countable income to the applicable percentage of the federal poverty guideline for a two-person household. If the deemed income of the ineligible spouse does not exceed the allocation for a spouse, only the eligible spouse's income is counted and compared to the applicable percentage of the poverty guideline for a one-person household.

(iv) The eligibility agency may not count SSI income to determine eligibility for QMB, SLMB or QI assistance.

(f) If any parent in the home receives SSI or is eligible for 1619(b) protected group coverage, the eligibility agency may not count the income of either parent to determine a child's eligibility for B or D Medicaid.

(g) Payments for providing foster care to a child are countable income. The portion of the payment that represents a reimbursement for the expenses related to providing foster care is not countable income.

(16) For Institutional Medicaid, the eligibility agency may only count the client in the household size. Only the client's income and deemed income from an alien client's sponsor is counted to determine the cost of care contribution. The provisions in Rule R414-307 govern who to include in the household size and whose income is counted to determine eligibility for home and community-based waiver services and the cost-of-care contribution.

(17) The eligibility agency shall deem, and count as unearned income, both unearned and earned income from an alien's sponsor and the sponsor's spouse when the sponsor signs an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act after December 18, 1997.

(a) The eligibility agency shall end sponsor deeming when the alien becomes a naturalized United States (U.S.) citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act, or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

(b) The eligibility agency may not apply sponsor deeming to applicants or recipients who are eligible for Medicaid for emergency services only, or who are eligible for Medicaid as described in Subsection R414-302-3(2).

(18) If retirement income has been divided between divorced spouses by the divorce decree pursuant to a Qualified Domestic Relations Order, the eligibility agency may only count as income the amount that is paid to the individual.

(19) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian Money Account Litigation Settlement under the Claims Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(20) The eligibility agency may not count as income any federal tax refund and refundable credit that an individual receives in accordance with the requirements of Sec. 6409, Pub. L. 112 240.

(21) The eligibility agency may not count income that is derived from an ownership interest in certain property and rights of federally-recognized American Indians and Alaska Natives including:

(a) certain tribal lands held in trust which are located on or near a reservation, or allotted lands located on a previous reservation;

(b) ownership interests in rents, leases, royalties, or usage rights related to natural resources that include extraction of natural resources; and

(c) ownership interests and usage rights in personal property which has unique religious, spiritual, traditional, or cultural significance, and rights that support subsistence or traditional lifestyles, as defined in Section 5006(b)(1) of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115.

(22) The eligibility agency may not count as income, payments from the Department of Workforce Services under the Family Employment program, the General Assistance program, or the Refugee Cash Assistance program.

R414-304-4. Medicaid Work Incentive Program Unearned Income Provisions.

(1) The Department adopts and incorporates by reference 20 CFR 416.1102, 416.1103, 416.1120 through 416.1124, 416.1140 through 416.1148, 416.1150, 416.1151, 416.1157, and Appendix to Subpart K of 416, October 1, 2012 ed. The Department also adopts and incorporates by reference Subsections 404(h)(4) and 1612(b)(24) and (25) of the Compilation of the Social Security Laws, effective January 1, 2013. The eligibility agency may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) The eligibility agency shall allow the provisions found in Subsection R414-304-3(2) through (13), and (17) through (21).

(3) The eligibility agency shall determine income from an ineligible spouse or parent by the total of the earned and unearned income using the appropriate exclusions in 20 CFR 416.1161, except that court ordered support payments are not allowed as an income deduction.

(4) For the MWI program, the income of a spouse or parent is not considered in determining eligibility of a person who receives SSI. SSI recipients who meet all other MWI program eligibility factors are eligible without paying a Medicaid buy-in premium.

(5) The eligibility agency shall determine household size and whose income counts for the MWI program as described below:

(a) If the MWI program individual is an adult and is not living with a spouse, the eligibility agency may only count the income of the individual. The eligibility agency shall include in the household size, any children of the individual who are under 18 years of age, or who are 18, 19, or 20 years of age and are full-time students. These children must be living in the home or be temporarily absent. After allowable deductions, the eligibility agency shall compare the countable income to 250% of the federal poverty guideline for the household size involved.

(b) If the MWI program individual is living with a spouse, the eligibility agency shall combine their income before allowing any deductions. The eligibility agency shall include in the household size the spouse and any children of the individual or spouse under 18 years of age, or who are 18, 19, or 20 years of age and are full-time students. These children must be living in the home or be temporarily absent. After allowable deductions, the eligibility agency shall compare the countable income of the MWI program individual and spouse to 250% of the federal poverty guideline for the household size involved.

(c) If the MWI program individual is a child living with a parent, the eligibility agency shall combine the income of the MWI program individual and the parents before allowing any deductions. The eligibility agency shall include in the household size the parents, any minor siblings, and siblings who are age 18, 19, or 20 and are full-time students, who are living in the home or temporarily absent. After allowable deductions, the eligibility agency shall compare the countable income of the MWI program individual and the individual's parents to 250% of the federal poverty guideline for the household size involved.

R414-304-5. MAGI-Based Coverage Groups.

(1) The Department adopts and incorporates by reference 42 CFR 435.603 (October 1, 2015), which applies to the methodology of determining household composition and income using the Modified Adjusted Gross Income (MAGI)-based methodology.

(a) The eligibility agency shall count in the household size, the number of unborn children that a pregnant household member expects to deliver.

(b) The Department elects the option in 42 CFR 435.603(f)(3)(iv)(B).

(c) The eligibility agency will treat separated spouses, who are not living together, as separate households.

(2) The eligibility agency may not count as income any payments from sources that federal law specifically prohibits from being counted as income to determine eligibility for federally-funded programs.

(3) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian Money Account Litigation Settlement under the Claims Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(4) The eligibility agency shall count as income cash support received by an individual when:

(a) it is received from the tax filer who claims a tax exemption for the individual;

(b) the individual is not a spouse or child of the tax filer; and

(c) the cash support exceeds a nominal amount set by the Department.

(5) To determine eligibility for MAGI-based coverage groups, the eligibility agency deducts an amount equal to 5% of the federal poverty guideline for the applicable household size from the MAGI-based household income determined for the individual. This deduction is allowed only to determine eligibility for the eligibility group with the highest income standard for which the individual may qualify.

R414-304-6. Unearned Income Provisions for Medically Needy Family, Child and Pregnant Woman Non-Institutional and Institutional Medicaid.

(1) The Department adopts and incorporates by reference 42 CFR 435.811 and 435.831,October 1, 2012 ed., 45 CFR 233.20(a)(1), 233.20(a)(3)(iv), 233.20(a)(3)(vi)(A), 233.20(a)(4)(ii), October 1, 2012 ed., and Subsection 404(h)(4) of the Compilation of the Social Security Laws, in effect January 1, 2013. The eligibility agency may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) The eligibility agency may not count as income money loaned to the individual if the individual proves the money is from a loan that the individual is expected to repay.

(3) The eligibility agency may not count as income support and maintenance assistance provided in-kind by a non-profit organization certified by the Department of Human Services.

(4) The eligibility agency may not count as income the value of food stamp assistance, USDA food donations or WIC vouchers received by members of the household.

(5) The eligibility agency may not count income that is received too irregularly or infrequently to count as regular income, such as cash gifts, up to $30 a calendar quarter per household member. Any amount that exceeds $30 a calendar quarter per household member

counts as income when received. Irregular or infrequent income may be divided equally among all members of the household.

(6) The eligibility agency may not count as income the amount deducted from benefit income to repay an overpayment.

(7) The eligibility agency may not count as income the value of special circumstance items paid for by donors.

(8) The eligibility agency may not count as income payments for home energy assistance.

(9) The eligibility agency may not count payments from any source that are to repair or replace lost, stolen or damaged exempt property. If the payments include an amount for temporary housing, the eligibility agency may only count the amount that the client does not intend to use or that is more than what is needed for temporary housing.

(10) The eligibility agency may not count as income SSA reimbursements of Medicare premiums.

(11) The eligibility agency may not count as income payments from the Department of Workforce Services under the Family Employment program, the General Assistance program, and the Refugee Cash Assistance program. To determine eligibility, the eligibility agency shall count income that the client receives to determine the amount of these payments, unless the income is an excluded income for medical assistance programs under other laws or regulations.

(12) The eligibility agency may not count as income interest or dividends earned on countable resources. The eligibility agency may not count as income interest or dividends earned on resources that are specifically excluded by federal laws from being counted as available resources to determine eligibility for federally-funded, means-tested medical assistance programs, other than resources excluded by 42 U.S.C. 1382b(a).

(13) The eligibility agency may not count as income the increase in pay for a member of the armed forces that is called "hostile fire pay" or "imminent danger pay," which is compensation for active military duty in a combat zone.

(14) The eligibility agency shall count as income SSI and State Supplemental payments received by children who are included in the coverage under medically needy Medicaid programs for families, pregnant women and children.

(15) The eligibility agency shall count unearned rental income. The eligibility agency shall deduct $30 a month from the rental income. If the amount charged for the rental is consistent with community standards, the eligibility agency shall deduct the greater of either $30 or the following actual expenses that the client can verify:

(a) taxes and attorney fees needed to make the income available;

(b) upkeep and repair costs necessary to maintain the current value of the property, including utility costs paid by the applicant or recipient;

(c) interest paid on a loan or mortgage made for upkeep or repair; and

(d) the value of a one-person food stamp allotment, if meals are provided to a boarder.

(16) The eligibility agency shall count deferred income when the client receives the income, the client does not defer the income by choice, and the client reasonably expects to receive the income. If the client defers the income by choice, the agency shall count the income according to when the client could receive the income. The eligibility agency shall count as income the amount deducted from income to pay for benefits like health insurance, medical expenses or child care in the month that the client could receive the income.

(17) The eligibility agency shall count the amount deducted from income to pay an obligation of child support, alimony or debts in the month that the client could receive the income.

(18) The eligibility agency shall count payments from trust funds as income in the month the payment is received by the individual or made available for the individual's use.

(19) The eligibility agency may only count as income the portion of a VA check to which the individual is legally entitled.

(20) The eligibility agency shall count as income deposits to financial accounts jointly-owned between the client and one or more other individuals, even if the deposits are made by a non-household member. If the client disputes ownership of the deposits and provides adequate proof that the deposits do not represent income to the client, the eligibility agency may not count those funds as income. The eligibility agency may require the client to terminate access to the jointly-held accounts.

(21) The eligibility agency shall count as unearned income the interest earned from a sales contract on lump sum payments and installment payments when the interest payment is received by or made available to the client.

(22) The eligibility agency shall count current child support payments as income to the child for whom the payments are being made. If a payment is for more than one child, the agency shall divide that amount equally among the children unless a court order indicates otherwise. Child support payments received by a parent or guardian to repay amounts owed for past months or years are countable income to determine eligibility of the parent or guardian who receives the payments. If ORS collects current child support, the eligibility agency shall count the child support as current even if ORS mails the payment to the client after the month it is collected.

(23) The eligibility agency shall count payments from annuities as unearned income in the month that the client receives the payments.

(24) If retirement income has been divided between divorced spouses by the divorce decree pursuant to a Qualified Domestic Relations Order, the eligibility agency may only count the amount paid to the individual.

(25) The eligibility agency shall deem, and count as unearned income, both unearned and earned income from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act after December 18, 1997.

(a) The eligibility agency shall stop deeming income from a sponsor when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

(b) The eligibility agency may not apply sponsor deeming to applicants or recipients who are eligible for emergency services only, or who are eligible for Medicaid as described in Subsection R414-302-3(2).

(26) The eligibility agency may not count as income any payments that an individual receives pursuant to the Individual Indian

Money Account Litigation Settlement under the Claims Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(27) The eligibility agency may not count as income any federal tax refund and refundable credit that an individual receives in accordance with the requirements of Sec. 6409 of the American Taxpayer Relief Act of 2012, Pub. L. No. 112 240, 126, Stat. 2313.

(28) The eligibility agency may not count income that is derived from an ownership interest in certain property and rights of federally-recognized American Indians and Alaska Natives including:

(a) certain tribal lands held in trust which are located on or near a reservation, or allotted lands located on a previous reservation;

(b) ownership interests in rents, leases, royalties, or usage rights related to natural resources that include extraction of natural resources; and

(c) ownership interests and usage rights in personal property which has unique religious, spiritual, traditional, or cultural significance, and rights that support subsistence or traditional lifestyles, as defined in Section 5006(b)(1) of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115.

R414-304-7. Aged, Blind and Disabled Non-Institutional and Institutional Medicaid Earned Income Provisions.

(1) The Department adopts and incorporates by reference 42 CFR 435.811 and 435.831, October 1, 2012 ed., and 20 CFR 416.1110 through 416.1112, April 1, 2012 ed. The Department may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) If an SSI recipient has a plan for achieving self-support approved by the (SSA), the eligibility agency may not count income set aside in the plan that allows the individual to purchase work-related equipment or meet self-support goals. This income may include earned and unearned income.

(3) The eligibility agency may not deduct from income expenses relating to the fulfillment of a plan to achieve self-support.

(4) For Aged, Blind and Disabled Medicaid, the eligibility agency may not count earned income used to compute a needs-based grant.

(5) For aged, blind and disabled Institutional Medicaid, the eligibility agency shall deduct $125 from earned income before it determines contribution towards cost of care.

(6) The eligibility agency shall include capital gains in the gross income from self-employment.

(7) To determine countable net income from self-employment, the eligibility agency shall allow a 40% flat rate exclusion off the gross self-employment income as a deduction for business expenses. For a self-employed individual who has allowable business expenses greater than the 40% flat rate exclusion amount and who also provides verification of the expenses, the eligibility agency shall calculate the self-employment net profit amount by using the deductions that are allowed under federal income tax rules.

(8) The eligibility agency may not allow deductions for the following business expenses:

(a) transportation to and from work;

(b) payments on the principal for business resources;

(c) net losses from previous tax years;

(d) taxes;

(e) money set aside for retirement; and

(f) work-related personal expenses.

(9) The eligibility agency may deduct net losses of self-employment from the current tax year from other earned income.

(10) The eligibility agency shall disregard earned income paid by the U.S. Census Bureau to temporary census takers to prepare for and conduct the census, for individuals defined in 42 CFR 435.120, 435.122, 435.130 through 435.135, 435.137, 435.138, 435.139, 435.211, 435.320, 435.322, 435.324, 435.340, 435.350 and 435.541. The eligibility agency shall also exclude this income for individuals described in Subsections 1634(b), (c) and (d), 1902(a)(10)(A)(i)(II), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII) and 1902(a)(10)(E)(i) through (iv) of Title XIX of the Social Security Act. The eligibility agency may not exclude earnings paid to temporary census takers from the post-eligibility process of determining the person's cost of care contribution for long-term care recipients.

(11) The eligibility agency shall count deductions from earned income that include insurance premiums, savings, garnishments, or deferred income in the month when the client could receive the funds.

R414-304-8. Earned Income Provisions for Medically Needy Family, Child and Pregnant Woman Non-Institutional and Institutional Medicaid.

(1) The Department adopts and incorporates by reference 42 CFR 435.811, 435.831, October 1, 2012 ed., and 45 CFR 233.20(a)(6)(iii) through (iv), 233.20(a)(6)(v)(B), 233.20(a)(6)(vi) through (vii), and 233.20(a)(11), October 1, 2012 ed. The eligibility agency may not count as income any payments from sources that federal laws specifically prohibit from being counted as income to determine eligibility for federally-funded medical assistance programs.

(2) The eligibility agency may not count the income of a dependent child if the child is:

(a) in school or training full-time;

(b) in school or training part-time, which means the child is enrolled for at least half of the hours needed to complete a course, or is enrolled in at least two classes or two hours of school a day and employed less than 100 hours a month; or

(c) is in a job placement under the federal Workforce Investment Act.

(3) For medically needy Family Medicaid, the eligibility agency shall allow the AFDC $30 and one-third of earned income deduction if the wage earner receives Parent/Caretaker Relative Medicaid in one of the four previous months and this disregard is not exhausted.

(4) The eligibility agency shall determine countable net income from self-employment by allowing a 40 % flat rate exclusion off the gross self-employment income as a deduction for business expenses. If a self-employed individual provides verification of actual

business expenses greater than the 40 % flat rate exclusion amount, the eligibility agency shall allow actual expenses to be deducted. The expenses must be business expenses allowed under federal income tax rules.

(5) Items such as personal business and entertainment expenses, personal transportation, purchase of capital equipment, and payments on the principal of loans for capital assets or durable goods, are not business expenses.

(6) For Family Medicaid, the eligibility agency shall deduct from the income of clients who work at least 100 hours in a calendar month a maximum of $200 a month in child care costs for each child who is under the age of two and $175 a month in child care costs for each child who is at least two years of age. The maximum deduction of $175 shall also apply to provide care for an incapacitated adult. The eligibility agency shall deduct from the income of clients who work less than 100 hours in a calendar month a maximum of $160 a month in child care costs for each child who is under the age of two and $140 a month for each child who is at least two years of age. The maximum deduction of $140 a month shall also apply to provide care for an incapacitated adult.

(7) For Family Institutional Medicaid, the eligibility agency shall deduct a maximum of $160 in child care costs from the earned income of clients who work at least 100 hours in a calendar month. The eligibility agency shall deduct a maximum of $130 in child care costs from the earned income of clients working less than 100 hours in a calendar month.

(8) The eligibility agency shall exclude earned income paid by the U.S. Census Bureau to temporary census takers to prepare for and conduct the census, for individuals defined in 42 CFR 435.301(b)1, 435.308, 435.310 and individuals defined in Title XIX of the Social Security Act Section 1902(e)(1), (7), and Section 1925. The eligibility agency may not exclude earnings paid to temporary census takers from the post-eligibility process of determining the person's cost of care contribution for long-term care recipients.

R414-304-9. Aged, Blind and Disabled Non-Institutional Medicaid and Medically Needy Family, Pregnant Woman and Child Non-Institutional Medicaid Income Deductions.

(1) The Department shall determine income deductions based on the financial methodologies in 42 CFR 435.601, and the deductions defined in 42 CFR 435.831.

(2) For aged, blind and disabled individuals eligible under 42 CFR 435.301(b)(2)(iii), (iv), and (v), described more fully in 42 CFR 435.320, .322 and .324, the eligibility agency shall deduct from income an amount equal to the difference between 100% of the federal poverty guideline and the current BMS income standard for the applicable household size to determine the spenddown amount.

(3) Health insurance premiums:

(a) The eligibility agency shall deduct from income health insurance premiums the client or a financially responsible family member pays. The coverage must be for the client or any family members living with the client. The eligibility agency shall also deduct from income premiums the Department pays on behalf of the client as authorized by Section 1905(a) of Title XIX of the Compilation of the Social Security Laws, except no deduction is allowed for Medicare premiums the Department pays for recipients.

(b) For Aged, Blind and Disabled programs, the eligibility agency shall deduct the entire payment in the month it is due and may not prorate the amount.

(c) For Medically Needy Family, Pregnant Woman and Child programs, factor premiums due weekly or bi-weekly before deducting. For payments due on any other basis, deduct the actual amount in the month due.

(d) The eligibility agency may not deduct health insurance premiums to determine eligibility for the poverty-related medical assistance programs or coverage groups subject to the use of MAGI-based methodologies.

(e) For medically needy programs, the actual amount of insurance premiums paid in a retroactive month will be deducted as follows:

(i) Deducted in the month paid; or

(ii) Deducted in a month after it was paid, but only through the month of application and only to the extent it was not already used as a deduction.

(5) To determine eligibility for medically needy coverage groups, the eligibility agency shall deduct from income medically necessary expenses that the client verifies only if the expenses meet all of the following conditions:

(a) The medical service was received by the client, a client's spouse, a parent of a dependent client, a dependent sibling of a dependent client, a deceased spouse, or a deceased dependent child;

(b) Medicaid does not cover the medical bill and it is not payable by a third party;

(c) The medical bill remains unpaid or the client receives and pays for the medical service during the month of application or during the three months immediately preceding the date of application. The date that the medical service is provided on an unpaid expense is irrelevant if the client still owes the provider for the service. Bills for services that the client receives and pays for during the application month or the three months preceding the date of application can be used as deductions only through the month of application.

(6) The eligibility agency may not allow a medical expense as a deduction more than once.

(7) The eligibility agency may only allow as an income deduction a medical expense for a medically necessary service. The eligibility agency shall determine whether the service is medically necessary.

(8) The eligibility agency shall deduct medical expenses in the order required by 42 CFR 435.831(h)(1). When expenses have the same priority, the eligibility agency shall deduct paid expenses before unpaid expenses.

(9) A client who pays a cash spenddown may present proof of medical expenses paid during the coverage month and request a refund of spenddown paid up to the amount of bills paid by the client. The following criteria apply:

(a) Expenses for which a refund can be made include medically necessary expenses not covered by Medicaid or any third party, co-payments required for prescription drugs covered under a Medicare Part D plan, and co-payments or co-insurance amounts for Medicaid-covered services as required under the Utah Medicaid State Plan;

(b) The expense must be for a service that the client receives during the benefit month;

(c) The Department may not refund any portion of any medical expense that the client uses to meet a Medicaid spenddown when

the client assumes responsibility to pay that expense;

(d) A refund cannot exceed the actual cash spenddown amount paid by the client;

(e) The Department may not refund spenddown amounts that a client pays based on unpaid medical expenses for services that the client receives during the benefit month. The client may present to the eligibility agency any unpaid bills for non-Medicaid-covered services that the client receives during the coverage month. The client may use the unpaid bills to meet or reduce the spenddown that the client owes for a future month of Medicaid coverage to the extent that the bills remain unpaid at the beginning of the future month;

(f) The Department shall reduce the refund amount by the amount of any unpaid obligation that the client owes the Department.

(10) For poverty-related coverage groups and coverage groups subject to the MAGI-based methodologies, an individual or household is ineligible if countable income exceeds the applicable income limit. The eligibility agency may not deduct medical costs from income to determine eligibility for poverty-related or MAGI-based medical assistance programs. An individual may not pay the difference between countable income and the applicable income limit to become eligible for poverty-related or MAGI-based medical assistance programs.

(11) When a client must meet a spenddown to become eligible for a medically needy program, the client must sign a statement that says:

(a) the eligibility agency told the client how spenddown can be met;

(b) the client expects his or her medical expenses to exceed the spenddown amount;

(c) whether the client intends to pay cash or use medical expenses to meet the spenddown; and

(d) that the eligibility agency told the client that the Medicaid provider may not use the provider's funds to pay the client's spenddown and that the provider may not loan the client money for the client to pay the spenddown.

(12) A client may meet the spenddown by paying the eligibility agency, or by providing proof to the eligibility agency of medical expenses the client owes equal to the spenddown amount.

(a) The client may elect to deduct from countable income unpaid medical expenses for services the client receives in non-Medicaid covered months to meet or reduce the spenddown.

(b) Expenses must meet the criteria for allowable medical expenses.

(c) Expenses may not be payable by Medicaid or a third party.

(d) For each benefit month, the client may choose to change the method of meeting the spenddown.

(13) The eligibility agency may not accept spenddown payments from a Medicaid provider if the source of the funds is the Medicaid provider's own funds. In addition, the eligibility agency may not accept spenddown payments from a client if a Medicaid provider loans funds to the client to make a spenddown payment.

(14) The eligibility agency may only deduct the amount of prepaid medical expenses equal to the cost of services received during the month in which the client pays the expenses. The eligibility agency may not deduct from income any payments a client makes for medical services in a month before the client receives the service.

(15) The eligibility agency may not require a client to pay a spenddown of less than $1.

(16) Medical costs that a client incurs in a benefit month may not be used to meet a spenddown when the client is enrolled in a Medicaid health plan.

(17) Bills for mental health services that a client incurs in a benefit month may not be used to meet spenddown if Medicaid contracts with a single mental health provider to provide mental health services to all recipients in the client's county of residence.

(18) Bills for mental health services a client pays in a retroactive or application month may be used to meet a spenddown if the services were not provided by a Medicaid-contracted mental health provider.

R414-304-10. Medicaid Work Incentive Program Income Deductions.

(1) To determine eligibility for the MWI program, the eligibility agency shall deduct the following amounts from income to determine countable income that is compared to 250% of the federal poverty guideline:

(a) $20 from unearned income. If there is less than $20 in unearned income, the eligibility agency shall deduct the balance of the $20 from earned income;

(b) Impairment-related work expenses;

(c) $65 plus one-half of the remaining earned income;

(d) A current year loss from a self-employment business can be deducted only from other earned income.

(2) For the MWI program, an individual or household is ineligible if countable income exceeds the applicable income limit. The eligibility agency may not deduct health insurance premiums and medical costs from income before comparing countable income to the applicable limit.

(3) The eligibility agency shall deduct from countable income the amount of health insurance premiums paid by the MWI-eligible individual or a financially responsible household member, to purchase health insurance for himself or other family members in the household before determining the MWI buy-in premium.

(4) An eligible individual may meet the MWI buy-in premium with cash, check or money order payable to the eligibility agency. The client may not meet the MWI premium with medical expenses.

(5) The eligibility agency may not require a client to pay a MWI buy-in premium of less than $1.

R414-304-11. Aged, Blind and Disabled Institutional Medicaid and Family Institutional Medicaid Income Deductions.

(1) The Department shall determine income deductions based on the financial methodologies in 42 CFR 435.601 and the deductions defined in 42 CFR 435.725, 435.726, 435.832, and 42 USC 1396a(r)(1), and 1396r-5(d).

(2) Health insurance premiums:

(a) For institutionalized and waiver eligible clients, the eligibility agency shall deduct from income health insurance premiums only for the institutionalized or waiver eligible client and only if paid with the institutionalized or waiver eligible client's funds. The eligibility agency shall deduct premiums the Department is paying on behalf of the client as authorized by Section 1905(a) of Title XIX of the Social Security Act, except no deduction is allowed for Medicare premiums that the Department pays for recipients.

(b) For Aged, Blind and Disabled programs, the eligibility agency shall deduct health insurance premiums in the month the payment is due.

(c) For Medically Needy Family, Pregnant Woman and Child programs, factor premiums due weekly or bi-weekly before deducting. For payments due on any other basis, deduct the actual amount in the month due.

(d) The eligibility agency shall deduct from income the portion of a combined premium attributable to the institutionalized or waiver-eligible client if the combined premium includes a spouse or dependent family member. The client's portion must be paid from the funds of the institutionalized or waiver-eligible client.

(3) The eligibility agency may only deduct medical expenses from income under the following conditions:

(a) the client receives the medical service;

(b) Medicaid or a third party will not pay the medical bill;

(c) a paid medical bill can only be deducted through the month of payment. No portion of any paid bill can be deducted after the month of payment.

(4) The eligibility agency may not deduct from income to determine cost-of-care contribution for long-term care services, or when a client incurs expenses for medical or remedial care services, even if the expense remains unpaid when:

(a) a client is in a penalty period resulting from a transfer of assets; or

(b) a client's residential home exceeds the equity value as defined in 42 U.S.C. 1396p(f).

(5) The eligibility agency may not allow a medical expense as an income deduction more than once.

(6) The eligibility agency may only allow as an income deduction a medical expense for a medically necessary service. The eligibility agency shall determine whether the service is medically necessary.

(7) The eligibility agency may only deduct the amount of prepaid medical expenses equal to the cost of services received during the month in which the client pays the expenses. The eligibility agency may not deduct from income any payments a client makes for medical services in a month before the client receives the service.

(8) When a client must meet a spenddown to become eligible for a medically needy program or receive Medicaid under a home and community based care waiver, the client must sign a statement that says:

(a) the eligibility agency told the client how spenddown can be met;

(b) the client expects his or her medical expenses to exceed the spenddown amount;

(c) whether the client intends to pay cash or use medical expenses to meet the spenddown; and

(d) the eligibility agency told the client that Medicaid providers may not use the provider's funds to pay the client's spenddown or loan the client money for the client to pay the spenddown.

(9) A client may meet the spenddown by paying the eligibility agency, or by providing proof to the eligibility agency of medical expenses the client owes equal to the spenddown amount.

(a) The client may elect to deduct from countable income unpaid medical expenses for services the client receives in non-Medicaid-covered months to meet or reduce the spenddown.

(b) Expenses must meet the criteria for allowable medical expenses.

(c) Expenses may not be payable by Medicaid or a third party.

(d) For each benefit month, the client may choose to change the method of meeting spenddown by either presenting proof of allowable medical expenses to the eligibility agency or by making a payment to the eligibility agency equal to the spenddown amount.

(10) The eligibility agency may not accept spenddown payments from a Medicaid provider if the source of the funds is the Medicaid provider's own funds. In addition, the eligibility agency may not accept spenddown payments from a client if a Medicaid provider loans funds to the client to make a spenddown payment.

(11) The eligibility agency shall require institutionalized clients to pay all countable income remaining after allowable income deductions to the institution in which an individual resides, as the individual's cost-of-care contribution.

(12) A client who pays a cash spenddown or a cost-of-care amount to the medical facility in which he resides, may present proof of medical expenses paid during the coverage month and request a refund of spenddown or cost-of-care paid up to the amount of bills. The following criteria apply:

(a) Expenses for which a refund can be made include medically necessary medical expenses not covered by Medicaid or any third party, co-payments required for prescription drugs covered under a Medicare Part D plan, and co-payments or co-insurance amounts for Medicaid-covered services as required under the Utah Medicaid State Plan;

(b) The expense must be for a service the client receives during the benefit month;

(c) The eligibility agency may not refund any portion of a medical expense the client uses to meet a Medicaid spenddown or to reduce his cost-of-care to the institution when the client assumes that payment responsibility;

(d) A refund cannot exceed the actual cash spenddown or cost-of-care amount paid by the client;

(e) The eligibility agency may not refund a spenddown or cost-of-care amounts paid by a client based on unpaid medical expenses for services the client receives during the benefit month. The client may present to the eligibility agency any unpaid bills for non-Medicaid-covered services the client receives during the coverage month. The client may use these unpaid bills to meet or reduce the spenddown the client owes for a future month of Medicaid coverage to the extent the bills remain unpaid at the beginning of the future month, and the bills are not payable by a third party;

(f) The Department shall reduce a refund by the amount of any unpaid obligation the client owes the Department.

(13) The eligibility agency shall deduct a personal needs allowance for residents of medical institutions equal to $45.

(14) When a doctor verifies a single person or a person whose spouse resides in a medical institution is expected to return home within six months of entering a medical institution or nursing home, the eligibility agency shall deduct a personal needs allowance equal to the BMS for one person defined in Subsection R414-304-13(6), for up to six months to maintain the individual's community residence.

(15) A client is not eligible for Medicaid coverage if medical costs are not at least equal to the contribution required towards the cost of care.

(16) Medical costs a client incurs in a benefit month may not be used to meet a spenddown when the client is enrolled in a Medicaid health plan.

(17) Bills for mental health services a client incurs in a benefit month may not be used to meet a spenddown if Medicaid contracts with a single mental health provider to provide mental health services to all recipients in the client's county of residence.

(18) Bills for mental health services a client pays in a retroactive or application month may be used to meet a spenddown if the services are not provided by a Medicaid-contracted mental health provider.

R414-304-12. Budgeting.

(1) The Department adopts and incorporates by reference 42 CFR 435.601 and 435.640, October 1, 2012 ed., and 45 CFR 233.20(a)(3)(iii), 233.31, and 233.33, October 1, 2012 ed., relating to financial responsibility and budgeting for non-MAGI-based Medicaid coverage groups.

(2) The Department adopts and incorporates by reference, 42 CFR 435.603(c), (d), (e), (g) and (h), October 1, 2012 ed., relating to household income and budgeting for MAGI-based Medicaid coverage groups.

(3) The eligibility agency shall do prospective budgeting to determine a household's expected monthly income.

(a) The eligibility agency shall include in the best estimate of MAGI-based income, reasonably predictable income changes such as seasonal income or contract income to determine the average monthly income expected to be received during the certification period.

(b) The eligibility agency shall prorate income over the eligibility period to determine an average monthly income.

(4) A best estimate of income based on the best available information is considered an accurate reflection of client income in that month.

(5) The eligibility agency shall use the best estimate of income to be received or made available to the client in a month to determine eligibility. For individuals eligible under a medically needy coverage group, the best estimate of income is used to determine the individual's spenddown.

(6) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing.

(7) For non-MAGI-based coverage groups, the eligibility agency shall count income in the following manner:

(a) For QMB, SLMB, QI, MWI program, and aged, blind, disabled, and Institutional Medicaid income is counted as it is received. Income that is received weekly or every other week is not factored;

(b) For medically needy Family, Pregnant Woman and Child Medicaid programs, income that is received weekly or every other week is factored.

(8) Lump sums are income in the month received. Lump sum payments can be earned or unearned income.

(9) For non-MAGI-based coverage groups, income paid out under a contract is prorated over the time period the income is intended to cover to determine the countable income for each month. The prorated amount is used instead of actual income that a client receives to determine countable income for a month.

(10) To determine the average monthly income for farm and self-employment income, the eligibility agency shall determine the annual income earned during one or more past years, or other applicable time period, and factors in any current changes in expected income for future months. Less than one year's worth of income may be used if this income has recently begun, or a change occurs making past information unrepresentative of future income. The monthly average income is adjusted during the year when information about changes or expected changes is received by the eligibility agency.

(11) Countable educational income that a client receives other than monthly income is prorated to determine the monthly countable income. This is done by dividing the total amount by the number of calendar months that classes are in session.

(12) Eligibility for retroactive assistance is based on the income received in the month for which retroactive coverage is sought. When income is being prorated or annualized, then the monthly countable income determined using this method is used for the months in the retroactive period, except when the income was not being received during, and was not intended to cover those specific months in the retroactive period.

R414-304-13. Income Standards.

(1) The Department adopts and incorporates by reference Subsections 1902(a)(10)(E), 1902(l), 1902(m), 1903(f), and 1905(p) of the Compilation of the Social Security Laws, in effect January 1, 2013.

(2) The eligibility agency shall calculate the aged and disabled poverty-related Medicaid income standard as 100% of the federal non-farm poverty guideline. If an aged or disabled person's income exceeds this amount, the Basic Maintenance Standard (BMS) applies unless the disabled individual or a disabled aged individual has earned income. In that case, the income standards of the MWI program apply.

(3) The income standard for the MWI for disabled individuals with earned income is equal to 250% of the federal poverty guideline for a family of the size involved. If income exceeds this amount, the BMS applies.

(a) The eligibility agency shall charge a MWI buy-in premium for the MWI program when the countable income of the eligible individual's or the couple's income exceeds 100% of the federal poverty guideline for the Aged and Disabled 100% poverty-related coverage group. When the eligible individual is a minor child, the eligibility agency shall charge a MWI buy-in premium when the child's

countable income, including income deemed from parents, exceeds 100% of the federal poverty guideline for a one-person household.

(b) The premium is equal to 5% of income when income is over 100% but not more than 110% of the federal poverty guideline, 10% of income when income is over 110% but not over 120% of the federal poverty guideline, or 15% of income when income is over 120% of the federal poverty guideline. The premium is calculated using only the eligible individual's or eligible couple's countable income multiplied by the applicable percentage.

(4) The income limit for parents and caretaker relatives, pregnant women, and children under the age of 19 are defined in Section R414-303-4.

(5) To determine eligibility and the spenddown amount of individuals under medically needy coverage groups, the BMS applies.

(6) The BMS is as follows:

TABLE

Household Size	Basic Maintenance Standard (BMS)
1	382
2	468
3	583
4	683
5	777
6	857
7	897
8	938
9	982
10	1,023
11	1,066
12	1,108
13	1,150
14	1,192
15	1,236
16	1,277
17	1,320
18	1,364

R414-304-14. Aged, Blind and Disabled Medicaid, Medicaid Work Incentive, QMB, SLMB, and QI Filing Unit.

(1) The Department adopts and incorporates by reference 42 CFR 435.601 and 435.602, October 1, 2012 ed., and Subsections 1902(m)(1) and (2), and 1905(p) of the Compilation of the Social Security Laws, in effect January 1, 2013.

(2) The eligibility agency shall count the following individuals in the BMS for aged, blind and disabled Medicaid:

(a) the client;

(b) a spouse who lives in the same home, if the spouse is eligible for aged, blind and disabled Medicaid, and is included in the coverage;

(c) a spouse who lives in the same home, if the spouse has deemed income above the allocation for a spouse.

(3) The eligibility agency shall count the following individuals in the household size for the 100% of poverty aged or disabled Medicaid program:

(a) the client;

(b) a spouse who lives in the same home, if the spouse is aged, blind, or disabled, regardless of the type of income the spouse receives, or whether the spouse is included in the coverage;

(c) a spouse who lives in the same home, if the spouse is not aged, blind or disabled, but has deemed income above the allocation for a spouse.

(4) The eligibility agency shall count the following individuals in the household size for a QMB, SLMB, or QI case:

(a) the client;

(b) a spouse living in the same home who receives Part A Medicare or is Aged, Blind, or Disabled, regardless of whether the spouse has any deemed income or whether the spouse is included in the coverage;

(c) a spouse living in the same home who does not receive Part A Medicare and is not Aged, Blind, or Disabled, if the spouse has deemed income above the allocation for a spouse.

(5) The eligibility agency shall count the following individuals in the household size for the MWI program:

(a) the client;

(b) a spouse living in the same home;

(c) parents living with a minor child;

(d) children who are under the age of 18;

(e) children who are 18, 19, or 20 years of age if they are in school full-time.

(6) Eligibility for aged, blind and disabled non-institutional Medicaid and the spenddown, if any; aged and disabled 100%

poverty-related Medicaid; and QMB, SLMB, and QI programs is based on the income of the following individuals:

(a) the client;

(b) parents living with the minor client;

(c) a spouse who is living with the client. Income of the spouse is counted based on Section R414-304-3;

(d) an alien client's sponsor, and the spouse of the sponsor, if any.

(7) Eligibility for the MWI program is based on income of the following individuals:

(a) the client;

(b) parents living with the minor client;

(c) a spouse who is living with the client;

(d) an alien client's sponsor, and the spouse of the sponsor, if any.

(8) If a person is included in the BMS, it means that the eligibility agency shall count that family member as part of the household and also count his income and resources to determine eligibility for the household, whether or not that family member receives medical assistance.

(9) If a person is included in the household size, it means that the eligibility agency shall count that family member as part of the household to determine what income limit applies, regardless of whether the agency counts that family member's income or whether that family member receives medical assistance.

R414-304-15. Medically Needy Family, Pregnant Woman and Child Medicaid Filing Unit.

(1) The Department adopts and incorporates by reference 42 CFR 435.601 and 435.602, October 1, 2012 ed., and 45 CFR 206.10(a)(1)(iii), 233.20(a)(1) and 233.20(a)(3)(vi), October 1, 2012 ed.

(2) If a household includes individuals who meet the U.S. citizen or qualified alien status requirements and family members who do not meet U.S. citizen or qualified alien status requirements, the eligibility agency shall include the ineligible alien family members in the household size to determine the applicable income limit for the eligible family members. The ineligible alien family members may not receive regular Medicaid coverage, but may be able to qualify for Medicaid that covers emergency services only under other provisions of Medicaid law.

(3) The eligibility agency may exclude any unemancipated minor child from the Medicaid coverage group, and may exclude an ineligible alien child from the household size at the request of the named relative who is responsible for the children. An excluded child is considered an ineligible child and is not counted as part of the household size to determine what income limit is applicable to the family. The eligibility agency may not consider income and resources of an excluded child to determine eligibility or spenddown.

(4) The eligibility agency may not include a non-parent caretaker relative in the household size of the minor child.

(5) If anyone in the household is pregnant, the eligibility agency shall include the expected number of unborn children in the household size.

(6) If the parents voluntarily place a child in foster care and in the custody of a state agency, the eligibility agency shall include the parents in the household size.

(7) The eligibility agency may not include parents in the household size who have relinquished their parental rights.

(8) If a court order places a child in the custody of the state and the state temporarily places the child in an institution, the eligibility agency may not include the parents in the household size.

(9) If the eligibility agency includes or counts a person in the household size, that family member is counted as part of the household and his income and resources are counted to determine eligibility for the household, whether or not that family member receives medical assistance. The household size determines which BMS income level applies to determine eligibility for the client or family.

R414-304-16. Aged, Blind and Disabled Institutional Family Institutional Medicaid Filing Unit.

(1) For aged, blind and disabled institutional Medicaid, the eligibility agency may not use income of the client's parents or the client's spouse to determine eligibility and the contribution to cost-of-care.

(2) For family institutional Medicaid programs, the Department adopts and incorporates by reference 45 CFR 206.10(a)(1)(vii), October 1, 2012 ed.

(3) The eligibility agency shall determine eligibility and the contribution to cost of care, which may be referred to as a spenddown, using the income of the client and the income deemed from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act after December 18, 1997. The eligibility agency shall end sponsor deeming when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

R414-304-17. Public Health Emergency Income Provisions.

The following treatment of certain income applies as defined in this section.

(1) The Department shall exclude from income the $600 per week federal pandemic unemployment payments as defined in Section 2102 and 2104(b) of the Coronavirus Aid, Relief, and Economic Security (Cares) Act, Pub. L. No. 116 136, for programs established under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.

(2) The Department shall exclude from income the recovery rebates for individuals as defined in Section 2201 of the Cares Act, for programs established under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. These rebates are treated as a refundable tax credit and may be paid in advance or upon filing a 2020 tax return.

(3) The Department shall exclude from income certain employer payments of student loans as defined in Section 2206 of the

Cares Act, Pub. L. No. 116 136 for coverage groups subject to the use of MAGI-based methodologies as defined in Section R414-304-5.

(a) Payments toward an employee's student loans may be paid directly to the employee or to the lender.

(b) This exclusion applies to payments made on or after the effective date of Pub. L. No. 116 136 and before January 1, 2021.

(4) The Department shall exclude the amount of qualified charitable contributions made by individuals during the taxable year as defined in Section 2204 of the Cares Act, Pub. L. No. 116 136, for coverage groups subject to the use of MAGI-based methodologies as defined in Section R414-304-5.

(a) Allowable taxable years begin in the year 2020.

(b) The excluded contributions must not exceed $300.

KEY: financial disclosures, income, budgeting
Date of Enactment or Last Substantive Amendment: September 16, 2020
Notice of Continuation: January 8, 2018
Authorizing, and Implemented or Interpreted Law: 26-18-3

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-305**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

General Information

2. Rule catchline:
Resources
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules, and 42 CFR 435.840 requires the Department to implement a single resource standard for each medically needy group.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it establishes resource provisions for categorically and medically needy individuals that include transfers, disregards, trusts and annuities, and how to apply modified adjusted gross income (MAGI)-based methodology.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/04/2023
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-305. Resources.
R414-305-1. Purpose and Authority.

This rule is established under the authority of Section 26-18-3 and establishes the resource provisions for Medicaid eligibility.

R414-305-2. Definitions.

(1) The definitions in Rules R414-1 and R414-301 apply to this rule.

(2) The following definitions apply in this rule:

(a) "Burial plot" means a burial space and any item related to repositories customarily used for the remains of any deceased member of the household. This includes caskets, concrete vaults, urns, crypts, grave markers, and the cost of opening and closing a grave site.

(b) "Penalty period" means a period of time during which a person is not eligible for Medicaid services for institutional care or

services provided under a home and community-based waiver due to a transfer of assets for less than fair market value.

(c) "Transfer" in regard to assets means a person has disposed of assets for less than fair market value.

R414-305-3. Aged, Blind and Disabled Non-Institutional and Institutional Medicaid Resource Provisions.

(1) To determine resource eligibility of an individual on the basis of being aged, blind or disabled, the Department adopts and incorporates by reference 42 CFR 435.840, 435.845, October 1, 2012 ed., and 20 CFR 416.1201, 416.1202, 416.1205 through 416.1224, 416.1229 through 416.1239, and 416.1247 through 416.1250, April 1, 2012 ed. The Department also adopts and incorporates by reference Section 1917(b), (d), (e), (f) and (g) of the Compilation of the Social Security Laws in effect January 1, 2013. The eligibility agency may not count as an available resource any assets that are prohibited under other federal laws from being counted as a resource to determine eligibility for federally-funded medical assistance programs. In addition, the eligibility agency applies the following rules.

(2) A resource is available when the individual owns it or has the legal right to sell or dispose of the resource for the individual's own benefit.

(3) Except for the Medicaid Work Incentive Program, the resource limit for aged, blind or disabled Medicaid is $2,000 for a one-person household and $3,000 for a two-person household.

(4) For an individual who meets the criteria for the Medicaid Work Incentive Program, the resource limit is $15,000. This limit applies whether the household size is one or more than one.

(5) The eligibility agency shall base non-institutional and institutional Medicaid eligibility on all available resources owned by the individual, or considered available to the individual from a spouse or parent. The eligibility agency may not grant eligibility based upon the individual's intent to or action of disposing of non-liquid resources as described in 20 CFR 416.1240, April 1, 2012 ed., unless Social Security is excluding the resources for an SSI recipient while the recipient takes steps to dispose of the excess resources.

(6) The eligibility agency may not count any resource or the interest from a resource held within the rules of the Uniform Transfers to Minors Act. Any money from the resource that is given to the child as unearned income is a countable resource that begins the month after the child receives it.

(7) The eligibility agency shall count the resources of a ward that are controlled by a legal guardian as the ward's resources.

(8) The eligibility agency may not count lump sum payments that an individual receives on a sales contract for the sale of an exempt home if the entire proceeds are used to purchase a new exempt home within three calendar months of when the property is sold. The eligibility agency shall grant the individual one three-month extension if more than three months is needed to complete the actual purchase. Proceeds are defined as all payments made on the principal of the contract. Proceeds do not include interest earned on the principal.

(9) If a resource is available, but a legal impediment exists, the eligibility agency may not count the resource until it becomes available. The individual must take appropriate steps to make the resource available unless one of the following conditions as determined by a person with established expertise relevant to the resource exists:

(a) Reasonable action does not allow the resource to become available; and

(b) The cost of making the resource available exceeds its value.

(10) Water rights attached to the home and the lot on which the home sits are exempt as long as the home is the individual's principal place of residence.

(11) For an institutionalized individual, the eligibility agency may not consider a home or life estate to be an exempt resource.

(12) To determine eligibility for nursing facility or other long-term care services, the eligibility agency shall exclude the value of the individual's principal home or life estate from countable resources if one of the following conditions is met:

(a) the individual intends to return to the home;

(b) the individual's spouse resides in the home;

(c) the individual's child who is under the age of 21, or who is blind or disabled resides in the home; or

(d) a reliant relative of the individual resides in the home.

(13) Even if the conditions in Subsection R414-305-3(12) are met, an individual is ineligible to receive nursing facility services or other long-term care services if the full equity value of the individual's home or life estate exceeds $500,000, or increased value according to the provisions of 42 U.S.C. 1396p(f)(1)(C) unless the individual's spouse, or the individual's child who is under the age of 21 or is blind or permanently disabled lawfully resides in the home. The individual may only qualify for Medicaid to cover ancillary services.

(14) For Aged, Blind and Disabled Medicaid, the eligibility agency may not count up to $6,000 of equity value of non-business property used to produce goods or services essential to home use daily activities.

(15) The eligibility agency may retroactively designate for burial a previously unreported resource that meets the criteria for burial funds found in 20 CFR 416.1231. The effective date of the exclusion cannot be earlier than the first day of the month after the month in which the funds were designated for burial or intended for burial, were separated from non-burial funds, and the client was eligible for Medicaid. The eligibility agency shall treat the resources as funds set aside for burial and the amount exempted cannot exceed the limit established for the SSI program.

(16) One vehicle is exempt if it is used for regular transportation needs of the individual or a household member.

(17) The eligibility agency may not count resources of an SSI recipient who has a plan for achieving self-support approved by the Social Security Administration when the resources are set aside under the plan to purchase work-related equipment or meet self-support goals.

(18) The eligibility agency may not count an irrevocable burial trust as a resource. Nevertheless, if the owner is institutionalized or on home and community-based waiver Medicaid, the value of the trust, which exceeds $7,000, is considered a transferred resource.

(19) The eligibility agency may not count business resources that are required for employment or self-employment.

(20) For the Medicaid Work Incentive Program, the eligibility agency may not count the following additional resources of the eligible individual:

(a) Retirement funds held in an employer or union pension plan, retirement plan or account, including 401(k) plans, or an Individual Retirement Account, even if the funds are available to the individual.

(b) A second vehicle when it is used by a spouse or child of the eligible individual living in the household to get to work.

(21) After qualifying for the Medicaid Work Incentive Program, the eligibility agency may not count the resources described in Subsection R414-305-3(20) to allow the individual to qualify for other Medicaid programs for the aged, blind or disabled, and not solely the Medicaid Work Incentive, even if the individual ceases to have earned income or no longer meets the criteria for the Work Incentive Program.

(22) Assets of an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act after December 18, 1997, are considered available to the alien. The eligibility agency shall stop counting assets from a sponsor when the alien becomes a naturalized United States (U.S.) citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

(23) The eligibility agency shall not consider a sponsor's assets as being available to applicants who are eligible for Medicaid for emergency services only.

(24) The eligibility agency may not count as a resource any federal tax refund and refundable credit that an individual receives for 12 months after the month of receipt.

(25) The eligibility agency may not count as a resource, for one year after the date of receipt, any payments that an individual receives under the Individual Indian Money Account Litigation Settlement under the Claims Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(26) The eligibility agency may not count certain property and rights of federally-recognized American Indians including certain tribal lands held in trust which are located on or near a reservation, or allotted lands located on a previous reservation; ownership interests in rents, leases, royalties or usage rights related to natural resources (including extraction of natural resources); and ownership interests and usage rights in personal property which has unique religious, spiritual, traditional or cultural significance, and rights that support subsistence or traditional lifestyles, as defined in Section 5006(b)(1) of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115.

(27) The eligibility agency shall not count as a resource a qualified Achieving a Better Life Experience (ABLE) account.

(28) The eligibility agency shall count only the portion of an asset such as a retirement plan that is legally available to an individual when that asset has been divided between two divorced spouses pursuant to a qualified domestic relations order.

(29) Under the authority of Subsection 1902(r)(2) of the Social Security Act, to determine an individual's eligibility for Medicaid for long-term care services, the Department disregards otherwise countable assets or resources in an amount equal to the insurance benefit payments made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy that meets the provisions found in 42 U.S.C. 1396p(b)(1)(C)(iii). The amount of the disregard applies to otherwise countable assets the client owns or that are deemed available to the client for the purpose of determining eligibility, and is equal to the amount of benefits the client has received from the partnership policy up through the month immediately before the month of application for long-term care assistance under Utah Medicaid.

(a) This resource disregard applies to aged, blind or disabled individuals who qualify for Medicaid under one of the following eligibility coverage groups found under:

(i) Subsection 1902(a)(10)(A)(ii)(V) of the Social Security Act; or

(ii) Subsection 1902(a)(10)(A)(ii)(VI) of the Social Security Act.

(b) The Department treats payments received after eligibility for long-term care services as a third-party liability that does not result in the disregard of additional resources.

(c) Assets disregarded under Subsection R414-305-3(28) are not subject to estate recovery authorized under Section 26-19-13.7, with the exception defined below in Subsection R414-305-3(28)(e).

(d) This disregard is not specific to any one asset. Any countable assets the individual owns or that are deemed available to the client are subject to the provisions defined in Section R414-305-9 regarding transfers of assets. The Department shall apply a penalty period or an overpayment proceeding for any transfer of assets for less than fair market value. In the event the Department learns of an asset transfer at the time of an estate recovery action for which a penalty period is not assessed or an overpayment is not collected, the Department shall reduce the amount of assets in the estate that could otherwise be excluded from the estate recovery requirements by the value of the assets transferred for less than fair market value. The Department may also take legal steps to recover assets transferred for less than fair market value.

(e) Home equity in excess of the standard described in Subsection R414-305-3(13) is not a countable resource, so this disregard does not affect the application of Subsection R414-305-3(13).

(f) The Department recognizes long-term care insurance partnership policies purchased in other states under the reciprocity requirements of the statute. The beneficiary of the policy must have been a resident in a partnership state when coverage first became effective under the policy.

(30) Life estates.

(a) For non-institutional Medicaid, the eligibility agency shall count life estates as resources only when a market exists for the sale of the life estate as established by knowledgeable sources.

(b) For Institutional Medicaid, the eligibility agency shall count life estates even if no market exists for the sale of the life estate,

unless the life estate can be excluded as defined in Subsection R414-305-3(12).

(c) The individual may dispute the value of the life estate by verifying the property value to be less than the established value or by submitting proof based on the age and life expectancy of the life estate owner that the value of the life estate is lower. The value of a life estate shall be based upon the age of the individual and the current market value of the property.

(d) The following table lists the life estate figure corresponding to the individual's age. The eligibility agency uses this figure to establish the value of a life estate:

TABLE

Age	Life Estate Figure
0	.97188
1	.98988
2	.99017
3	.99008
4	.98981
5	.98938
6	.98884
7	.98822
8	.98748
9	.98663
10	.98565
11	.98453
12	.98329
13	.98198
14	.98066
15	.97937
16	.97815
17	.97700
18	.97590
19	.97480
20	.97365
21	.97245
22	.97120
23	.96986
24	.96841
25	.96678
26	.96495
27	.96290
28	.96062
29	.95813
30	.95543
31	.95254
32	.94942
33	.94608
34	.94250
35	.93868
36	.93460
37	.93026
38	.92567
39	.92083
40	.91571
41	.91030
42	.90457
43	.89855
44	.89221
45	.88558
46	.87863
47	.87137
48	.86374

49	.85578
50	.84743
51	.83674
52	.82969
53	.82028
54	.81054
55	.80046
56	.79006
57	.77931
58	.76822
59	.75675
60	.74491
61	.73267
62	.72002
63	.70696
64	.69352
65	.67970
66	.66551
67	.65098
68	.63610
69	.62086
70	.60522
71	.58914
72	.57261
73	.55571
74	.53862
75	.52149
76	.50441
77	.48742
78	.47049
79	.45357
80	.43659
81	.41967
82	.40295
83	.38642
84	.36998
85	.35359
86	.33764
87	.32262
88	.30859
89	.29526
90	.28221
91	.26955
92	.25771
93	.24692
94	.23728
95	.22887
96	.22181
97	.21550
98	.21000
99	.20486
100	.19975
101	.19532
102	.19054
103	.18437
104	.17856
105	.16962
106	.15488
107	.13409
108	.10068

R414-305-4. Parents and Caretaker Relatives, Pregnant Woman and Child using MAGI methodology Resource Provisions.

The Department adopts 42 CFR 435.603(g), October 1, 2012 ed., which is incorporated by reference, regarding no resource test for coverage groups subject to MAGI-based methodologies for determining eligibility.

R414-305-5. Resource Provisions for Parents and Caretaker Relatives, Pregnant Woman, and Child Under Non-MAGI-Based Community and Institutional Medicaid.

(1) The Department determines resource eligibility for an individual under the Parents and Caretaker Relatives, Pregnant Woman, and Child non-MAGI-based Medicaid programs, as described in 45 CFR 233.20(a)(3)(i)(B)(1), (2), (3), (4), and (6), 233.20(a)(3)(vi)(A), 42 U.S.C. 604(h), 1382b(a)(13), and 1396p(d), (e), (f) and (g). The eligibility agency may not count as an available resource retained funds from sources that federal laws specifically prohibit from being counted as a resource to determine eligibility for federally-funded medical assistance programs. In addition, the eligibility agency shall apply the following rules.

(2) A resource is available when the individual owns it or has the legal right to sell or dispose of the resource for the individual's own benefit.

(3) The medically needy resource limit is $2,000 for a one-person household, $3,000 for a two-person household and $25 for each additional household member.

(4) To determine countable resources for Medicaid eligibility, the eligibility agency shall consider all available resources owned by the individual. The agency may not consider a resource unavailable based upon the individual's intent or action of disposing of non-liquid resources.

(5) The eligibility agency shall count resources of a household member who has been disqualified from Medicaid for failure to cooperate with third party liability or duty of support requirements.

(6) If a legal guardian, conservator, authorized representative, or other responsible person controls any resources of an individual, the eligibility agency shall count the resources as the individual's. The arrangement may be formal or informal.

(7) If a resource is available, but a legal impediment exists, the agency may not count the resource until it becomes available. The individual must take appropriate steps to make the resource available unless one of the following conditions exist:

(a) Reasonable action does not allow the resource to become available; and

(b) The cost of making the resource available exceeds its value.

(8) The eligibility agency shall exclude a maximum of $1,500 in equity value of one vehicle.

(9) The eligibility agency may not count as resources the value of household goods and personal belongings that are essential for day-to-day living. The agency shall count any single household good or personal belonging with a value that exceeds $1,000 toward the resource limit. The agency may not count as a resource the value of any item that a household member needs because of the household member's medical or physical condition.

(10) The eligibility agency may not count the value of one wedding ring and one engagement ring as a resource.

(11) For a non-institutionalized individual, the eligibility agency may not count the value of a life estate as an available resource if the life estate is the individual's principal residence. If the life estate is not the principal residence, the provision in Subsection R414-305-3(28) shall apply.

(12) The eligibility agency may not count the resources of a child who is not counted in the household size to determine eligibility of other household members.

(13) For a non-institutionalized individual, the eligibility agency may not count as a resource, the value of the lot on which the excluded home stands if the lot does not exceed the average size of residential lots for the community in which it is located. The agency shall count as a resource the value of the property in excess of an average size lot. If the individual is institutionalized, the provisions of Subsections R414-305-3(12), (13) and (28) shall apply to the individual's home or life estate.

(14) The agency may not count as a resource the value of water rights attached to an excluded home and lot.

(15) The eligibility agency may not count any resource or interest from a resource held within the rules of the Uniform Transfers to Minors Act. The agency shall count as a resource any money that a child receives as unearned income, which the child retains beyond the month of receipt.

(16) The eligibility agency may not count lump sum payments that an individual receives on a sales contract for the sale of an exempt home if the entire proceeds are used to purchase a new exempt home within three calendar months of when the property is sold. The eligibility agency shall grant the individual one three-month extension, if more than three months is needed to complete the actual purchase. Proceeds are defined as all payments made on the principal of the contract. Proceeds do not include interest earned on the principal.

(17) The eligibility agency shall exclude as a resource retroactive benefits received from the Social Security Administration and the Railroad Retirement Board for the first nine months after receipt.

(18) The eligibility agency shall exclude from resources a burial and funeral fund or funeral arrangement up to $1,500 for each household member who is counted in the household size. Burial and funeral agreements include burial trusts, funeral plans, and funds set aside expressly for the purposes of burial. The client shall separate and clearly designate the burial funds from the non-burial funds. The agency may not count as a resource interest earned on exempt burial funds that is left to accumulate. If an individual uses exempt burial funds for some other purpose, the agency shall count the remaining funds as an available resource beginning on the date that the funds are withdrawn.

(19) Assets of an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to

Section 213A of the Immigration and Nationality Act after December 18, 1997, are considered available to the alien. The eligibility agency shall stop counting a sponsor's assets when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. After December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public benefit.

(20) The eligibility agency may not consider a sponsor's assets as being available to applicants who are eligible for Medicaid for emergency services only.

(21) The eligibility agency may not count business resources that are required for employment or self-employment. The agency shall treat non-business, income-producing property in the same manner as the SSI program as defined in 42 CFR 416.1222.

(22) The eligibility agency may not count as a resource retirement funds held in an employer or union pension plan, a retirement plan or account including 401(k) plans, and Individual Retirement Accounts of a disabled parent or disabled spouse who is not included in the coverage.

(23) The eligibility agency may not count as a resource any federal tax refund and refundable credit that an individual receives for 12 months after the month of receipt.

(24) The eligibility agency may not count as income, for one year after the date of receipt, any payments that an individual receives under the Individual Indian Money Account Litigation Settlement under the Claims Resettlement Act of 2010, Pub. L. No. 111 291, 124 Stat. 3064.

(25) The eligibility agency may not count as resources certain property and rights of federally-recognized American Indians including:

(a) certain tribal lands held in trust which are located on or near a reservation, or allotted lands located on a previous reservation;

(b) ownership interests in rents, leases, royalties or usage rights related to natural resources (including extraction of natural resources); and

(c) ownership interests and usage rights in personal property which has unique religious, spiritual, traditional or cultural significance, and rights that support subsistence or traditional lifestyles, as defined in Section 5006(b)(1) of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111 5, 123 Stat. 115.

(26) The eligibility agency may not count as a resource, funds held in a Utah Educational Savings Plan for the following individuals:

(a) Medically Needy Children as described in Subsection 1902(a)(10)(C)(ii)(I) of the Social Security Act;

(b) Medically Needy Children as described in Subsection 1905(a)(i) of the Social Security Act, who are 18 years old, in school, and expected to graduate before turning 19 years of age;

(c) Medically Needy Pregnant Women as describe in Subsection 1902(a)(10)(C)(ii)(II) of the Social Security Act; and

(d) Medically Needy Parents and Caretaker Relatives as described in Subsection 1905(a)(ii) of the Social Security Act.

(27) The eligibility agency may only count the portion of an asset such as a retirement plan that is legally available to an individual when that asset has been divided between two divorced spouses pursuant to a qualified domestic relations order.

R414-305-6. Spousal Impoverishment Resource Rules for Married Institutionalized Individuals.

(1) The eligibility agency shall apply the provisions of 42 U.S.C. 1396r-5 to determine the value of the total joint resources of an institutionalized individual and a community spouse, and the spousal assessed share.

(2) The resource limit for an institutionalized individual is $2,000.

(3) At the request of either the institutionalized individual or the individual's spouse and upon receipt of relevant documentation of resources, the eligibility agency shall assess and document the total value of resources using the methodology described in Subsection R414-305-6(4) as of the first continuous period of institutionalization or upon application for Medicaid home and community-based waiver services. The eligibility agency shall notify the requester of the results of the assessment. The agency may not require the individual to apply for Medicaid or pay a fee for the assessment.

(4) The assessment is a computation of the total value of resources in which the institutionalized individual or the community spouse has an ownership interest. The spousal share is equal to one-half of the total value computed. The eligibility agency shall count the resources for the assessment that include those the couple has on the date that one spouse becomes institutionalized or applies for Medicaid for home and community-based waiver services, and the other spouse remains in the community and is not eligible for Medicaid for home and community-based waiver services.

(a) The community spouse's assessed share of resources is one-half of the total resources. Nevertheless, the protected resource allowance for the community spouse may be less than the assessed share.

(b) Upon application for Medicaid, the eligibility agency shall set the protected share of resources for the community spouse when countable resources equal no more than the community spouse's protected share as determined under 42 U.S.C. 1396r-5(f) plus the resource limit for the institutionalized spouse.

(c) The eligibility agency shall set the community spouse's protected share of resources at the community spouse's assessed share of the resources with the following exceptions:

(i) If the spouse's assessed share of resources is less than the minimum resource standard, the protected share of resources is the minimum resource standard;

(ii) If the spouse's assessed share of resources is more than the maximum resource standard, the protected share of resources is the maximum resource standard;

(iii) The eligibility agency shall use the minimum and maximum resource standards permitted under 42 U.S.C. 1396r-5(f) to determine the community spouse's protected share.

(d) In making a decision to modify the community spouse's protected share of resources, the eligibility agency shall apply the income first provisions of 42 U.S.C. 1396r-5(d)(6).

(5) The eligibility agency shall count any resource owned by the community spouse in excess of the community spouse's protected share of resources to determine the institutionalized individual's initial Medicaid eligibility.

(6) After the eligibility agency establishes eligibility for the institutionalized spouse, the agency shall allow a protected period for the couple to either use excess resources, or change the ownership of resources held jointly or held only in the name of the institutionalized spouse.

(a) The protected period continues until the resources held in the institutionalized spouse's name do not exceed $2,000, or until the time of the next regularly scheduled eligibility redetermination, whichever occurs first.

(b) The institutionalized individual may do the following:

(i) use resources held in his name for his benefit or for the benefit of his spouse;

(ii) transfer resources to the community spouse to bring the resources held only in the name of the community spouse up to the amount of the community spouse's protected share of resources and to bring the resources held only in the name of the institutionalized spouse down to the Medicaid resource limit; or

(iii) a combination of both.

(7) The eligibility agency may not count resources held in the name of the community spouse as available to the institutionalized spouse beginning the month after the month in which the agency establishes eligibility.

(8) If an individual is otherwise eligible for institutional Medicaid, the eligibility agency may not count the community spouse's resources as available to the institutionalized individual due to an uncooperative spouse or because the spouse cannot be located if all of the following criteria are met:

(a) The individual assigns support rights to the agency;

(b) The individual cannot get medical care without Medicaid;

(c) The individual is at risk of death or permanent disability without institutional care.

R414-305-7. Treatment of Trusts.

(1) The eligibility agency shall apply the criteria in 42 U.S.C. 1396a(k), to determine the availability of trusts established before August 11, 1993.

(a) A Medicaid qualifying trust is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust. The distribution of payments is determined by one or more trustees who are permitted to exercise some amount of discretion with respect to the distribution to the individual.

(b) The amount of the trust property that is counted as an available resource to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee is permitted to distribute under the terms of the trust for the individual's benefit. This amount of property is counted as available whether or not it is actually disbursed by the trustee or received by the beneficiary. It does not matter whether the trust is irrevocable or whether it is established for a purpose other than to qualify for Medicaid.

(c) Payments made from the available portion of the trust do not count as income because the available portion of the trust is counted as a resource. If payments are made from any portion of the trust that is not counted as a resource, the payments are counted as income in the month received.

(2) The Department adopts the provisions of 42 U.S.C. 1396p(d)(4)(A) concerning trusts for a Disabled Person under Age 65. These trusts are commonly known as a special needs trust for a disabled person. Assets held in a trust that complies with the provisions in Subsection R414-305-7(2) and (4) do not count as available resources.

(a) The trust must be established solely for the benefit of the disabled individual by the individual, a parent, grandparent, legal guardian of the individual, or a court. A trust established by the disabled individual must be established on or after December 13, 2016.

(b) The eligibility agency shall treat any additions to the trust corpus with assets not belonging to the disabled trust beneficiary as a gift to the trust beneficiary. The additions irrevocably become part of the trust corpus and are subject to all provisions of Medicaid restrictions that govern special needs trusts.

(c) The trust must be irrevocable. No one may have any right or power to alter, amend, revoke, or terminate the trust or any of its terms, except that the trust may include language that provides that the trust may be amended but only if necessary to conform with subsequent changes to the requirements of 42 U.S.C. 1396p(d)(4)(A) or synonymous state law.

(d) The trust cannot be altered or converted from an individual trust to a "pooled trust" under 42 U.S.C. 1396p(d)(4)(C).

(e) The trust must terminate upon the death of the disabled individual or exhaustion of trust corpus and must include language that specifically provides that upon the death of the beneficiary or early termination of the trust, whichever occurs first, the trustees will notify Medicaid and will pay all amounts remaining in the trust to the State up to the total amount of medical assistance the State has paid on behalf of the individual. The trust shall comply fully with this obligation to first repay the State without requiring the State to take any action except to establish the amount to be repaid.

(f) The sole lifetime beneficiary of the trust must be the disabled individual, and the Medicaid agency must be the preferred remainder beneficiary. Distributions from the trust during the beneficiary's lifetime may be made only to or for the benefit of the disabled individual.

(g) The eligibility agency shall continue to exclude assets held in the trust from countable resources after the disabled individual reaches age 65. Subsequent additions to the trust other than interest on the corpus after the person turns 65 are not assets of an individual under age 65 and the agency shall treat the transfer as a transfer of resources for less than fair market value, which may create a period of

ineligibility for certain Medicaid services.

(h) A trust that provides benefits to other persons is not an individual special needs trust and does not the meet the criteria to be excluded from resources.

(i) A corporate trustee may charge a reasonable fee for services.

(j) The trust may compensate a guardian only as provided by law. The trust may not compensate the parent of a minor child from the trust as the child's guardian.

(k) Additional trusts cannot be created within the special needs trust.

(3) The Department adopts the provisions of 42 U.S.C. 1396p(d)(4)(C) concerning pooled trusts for disabled individuals. A pooled trust is a specific trust for disabled individuals that meets all of the following conditions:

(a) The trust contains the assets of disabled individuals;

(b) The trust must be established and managed by an entity that has been granted non-profit status by the Internal Revenue Service. The non-profit entity must submit to the State a letter documenting the non-profit status with the trust documents;

(c) The trustees must maintain a separate account for each disabled beneficiary whose assets are placed in the pooled trust; however, for the purposes of investment and management of the funds, the trust may pool the funds from the individual accounts. If someone other than the beneficiary transfers assets to the pooled trust administrator to be used on behalf of that beneficiary of the pooled trust, the eligibility agency shall treat the assets as a gift to that beneficiary, which the administrator must add to and manage as part of the balance of the beneficiary's account and which are subject to all provisions of Medicaid restrictions that govern pooled trusts.

(d) Accounts in the trust must be established solely for the benefit of individuals who are disabled as defined in 42 U.S.C. 1382c(a)(3).

(e) The trust must be irrevocable; accounts set up in the trust must be irrevocable.

(f) Individual accounts may be established only by the parent, grandparent or legal guardian of the individual, by the individual, or by a court.

(g) An initial transfer of funds or any additions or augmentations to a pooled trust account by an individual 65 years of age or older is a transfer of assets for less than fair market value and may create a period of ineligibility for certain Medicaid services.

(h) The disabled individual cannot control any spending by the trust.

(i) Individual trust accounts may not be liquidated before the death of the beneficiary without first making payment to the State for medical assistance paid on behalf of the individual.

(j) The trust must include language that specifically provides that upon the death of the trust account beneficiary, the trustees will notify the Medicaid agency and will pay all amounts remaining in the beneficiary's account to the State up to the total medical assistance paid on behalf of the beneficiary. The trust may retain a maximum of 50% of the amount remaining in the beneficiary's account at death to be used for other disabled individuals if the trust has established provisions by which it will assure that the retained funds are used only for individuals meeting the disability criteria found in 42 U.S.C. 1382c(a)(3).

(k) A pooled trust that retains some portion of a deceased beneficiary's trust funds must describe how retained funds are used for other disabled persons. Any funds that are placed in an individual beneficiary's account or that are used to set up an account for an individual beneficiary who does not otherwise have funds to place in the pooled trust are subject to all of the provisions of Medicaid restrictions that govern pooled trusts. The pooled trust may include a plan for using retained funds only for incidental, one-time services to qualified disabled individuals who do not have accounts in the pooled trust.

(4) The following provisions apply to both individual trusts and pooled trusts described in Subsection R414-305-7(2) and (3):

(a) No expenditures may be made after the death of the beneficiary before repayment to the State, except for federal and state taxes and necessary and reasonable administrative costs of the trust incurred in closing the trust;

(b) The trust must provide that if the beneficiary has received Medicaid benefits in more than one state, each state that provided Medicaid benefits shall be repaid. If the remaining balance is insufficient to repay all benefits paid, then each state will be paid its proportionate share;

(c) The trust or an attached schedule must identify the amount and source of the initial trust property. The disabled individual must report subsequent additions to the trust corpus to the eligibility agency;

(d) If the trust is funded, in whole or in part, with an annuity or other periodic payment arrangement, the State must be named in controlling documents as the preferred remainder beneficiary in the first position up to the total amount of medical assistance paid on behalf of the individual;

(i) Any funds remaining after full repayment of the medical assistance can be paid to a secondary remainder beneficiary;

(ii) The eligibility agency shall treat any provision or action that does or will divert payments or principal from the annuity or payment arrangement to someone other than the excluded trust or the Medicaid agency as a transfer of assets for less than fair market value with the exception that any remainder after the Medicaid agency has been fully repaid may be paid to a secondary beneficiary;

(e) The eligibility agency shall count cash distributions from the trust as income in the month received;

(f) The eligibility agency shall count retained distributed amounts as resources beginning the month which follows the month that the amounts are distributed. The agency shall apply the applicable resource rules to assets purchased with trust funds and given to the beneficiary as his or her personal possessions. The disabled individual must report the receipt of payments or assets from the trust within ten days of receipt. The agency shall exclude assets purchased with trust funds if the trust retains ownership;

(g) The eligibility agency shall count distributions from the trust covering the individual's expenses for food or shelter as in-kind income to determine Medicaid eligibility in the month paid;

(h) If expenditures made from the trust also incidentally provide an ongoing and continuing benefit to other persons, those other

persons who also benefit must contribute a pro-rata share to the trust for the expenses associated with their use of the acquisition;

(i) Contracts to provide personal services to the disabled individual must be in writing, describe the services to be provided, pay fair market rate consistent with rates charged in the community for the type and quality of services to be provided, and be executed in advance of any services being provided and paid. The eligibility agency may require a statement of medical need for the services from the individual's medical practitioner. If the person who is to provide the services is a family member or friend, the eligibility agency may require verification of the person's ability to carry out the needed services;

(j) Distributions from the trust made to or for the benefit of a third party that are not for the benefit of the disabled individual are treated as a transfer of assets for less than fair market value and may create a period of ineligibility for certain Medicaid services. This includes such things as payments of the expenses or travel costs of persons other than a medically necessary attendant;

(k) The beneficiary must submit an annual accounting of trust income and expenditures and a statement of trust assets to the eligibility agency upon request or upon any change of trustee.

(5) The eligibility agency may not count assets held in a pooled trust that comply with the provisions in Subsection R414-305-7(3) and (4) as available resources.

(6) 42 U.S.C. 1396p(d)(4)(B), provides for an exemption from the trust provisions for qualified income trusts (also known as Miller Trusts). Special provisions for this form of trust apply, under federal law, only in those states that do not provide medically needy coverage for nursing facility services. Because Utah covers services in nursing facilities under the medically needy coverage group of the Medicaid program, the establishment of a qualified income trust shall be treated as an asset transfer for the purposes of qualifying for Medicaid. This presumption shall apply whether the individual is seeking nursing facility services or home and community-based services under one of the waiver programs.

R414-305-8. Transfer of Resources for Non-Institutional Medicaid Coverage Groups.

The eligibility agency may not impose a penalty period for the transfer of resources to determine eligibility for individuals who are not institutionalized or eligible for home and community-based services waivers.

R414-305-9. Transfer of Resources for Institutional Medicaid and Home and Community-Based Services Waivers.

(1) The eligibility agency shall apply 42 U.S.C. 1396p(c) and (e) to determine if a penalty period applies for a transfer of assets for less than fair market value.

(2) The transfer requirements of 42 U.S.C. 1396p(c) and (e) apply if an individual or the individual's spouse transfers the home, life estate, assets disregarded for eligibility purposes pursuant to Subsection R414-305-3(28), or any other asset on or after the look-back date based on an application for long-term care Medicaid services.

(3) If an individual or the individual's spouse transfers assets in more than one month after February 7, 2006, the uncompensated value of all transfers including fractional transfers are combined to determine the penalty period. The eligibility agency shall apply partial month penalty periods for transferred amounts that are less than the monthly average private-pay rate for nursing home services.

(4) In accordance with 42 U.S.C. 1396p(c), the penalty period for a transfer of assets that occurs after February 7, 2006, begins the first day of the month during or after which assets are transferred, or the date on which the individual is eligible for Medicaid coverage and would otherwise receive institutional level care based on an approved application for Medicaid, but for the application of the penalty period, whichever is later.

(a) If a previous penalty period is in effect on the date the new penalty period begins, the new penalty period begins immediately after the previous one ends.

(b) The eligibility agency shall apply penalty periods consecutively so they do not overlap.

(5) If assets are transferred during any penalty period, the penalty period for those transfers does not begin until the previous penalty period expires.

(6) If a transfer occurs, or the eligibility agency discovers an unreported transfer after the agency approves an individual for Medicaid for nursing home or home and community-based services, the penalty period shall begin on the first day of the month after the month that the individual transfers the asset.

(7) In determining the statewide average private-pay rate for nursing home care that the eligibility agency uses to calculate the penalty period for transfers, the Department uses the audited and finalized facility cost profile report from the previous state fiscal year, which it finalizes in May of the current fiscal year. The Department then calculates the statewide average private-pay rate using the total facilities private revenue divided by the total private days to get the revenue for each day, which is multiplied by 365 and then divided by 12. The current amount is found in Table II-A at this address: https://bepmanuals.health.utah.gov/Medicaidpolicy/DOHMedicaid.htm.

(8) To determine if a resource is transferred for the sole benefit of a spouse, disabled or blind child, or disabled individual, a binding written agreement must be in place which establishes that the resource transferred may only be used to benefit the spouse, disabled child, or disabled individual, and must be actuarially sound. The written agreement must specify the payment amounts and schedule. Any provisions in the agreement that benefit another person at any time nullify the sole benefit provision. An excluded trust established under 42 U.S.C. 1396p(d)(4) that meets the criteria in Section R414-305-7 does not have to meet the actuarially sound test.

(9) The eligibility agency may not impose a penalty period if the total value of a whole life insurance policy is:

(a) irrevocably assigned to the state;

(b) the recipient is the owner of and the insured in the policy; and

(c) no further premium payments are necessary for the policy to remain in effect.

(10) When the individual dies, the state shall distribute the benefits of the policy as follows.

(a) The state may distribute up to $7,000 to cover burial and funeral expenses. The total value of this distribution plus the value of any irrevocable burial trusts and the burial and funeral funds for the individual cannot exceed $7,000.

(b) The state may distribute an amount that does not exceed the total amount of previously unreimbursed medical assistance correctly paid on behalf of the individual.

(c) The state may distribute to a remainder beneficiary, named by the individual, any amount that remains after payments are made as defined in Subsection (10)(a)(b).

(11) If the eligibility agency determines that a penalty period applies for an otherwise eligible institutionalized person, the agency shall notify the individual that the Department may not pay the costs for nursing home or other long-term care services during the penalty period. The notice shall include when the penalty period begins and ends.

(a) The individual may request a waiver of the penalty period based on undue hardship.

(b) The individual must send a written request for a waiver of the penalty period due to undue hardship to the eligibility agency within 30 days of the date printed on the penalty period notice.

(c) The request must include an explanation of why the individual believes undue hardship exists.

(d) The eligibility agency shall decide on the undue hardship request within 30 days of receipt.

(12) An individual who claims an undue hardship as a result of a penalty period for a transfer of resources must meet both of the following conditions.

(a) The individual or the person who transferred the resources may not access the asset immediately; however, the eligibility agency shall require the individual to exhaust all reasonable means including legal remedies to regain possession of the transferred resource.

(b) The agency may determine it is unreasonable to require the individual to act if a knowledgeable source confirms the individual's efforts cannot succeed.

(c) The agency may determine that it is unreasonable to require the individual to take action based on evidence that the individual's action is more costly than the value of the resource.

(d) Application of the penalty period for a transfer of resources deprives the individual of medical care, endangers the individual's life or health, or deprives the individual of food, clothing, shelter, or other necessities of life.

(13) If the eligibility agency waives the penalty period based on undue hardship, the agency shall notify the individual. The Department shall provide Medicaid coverage on the condition that the individual takes all reasonable steps to regain the transferred assets. The eligibility agency shall notify the individual of the date that the individual must provide verifications of the steps taken. The individual must, within the time frames set by the agency, verify to the agency all reasonable actions. The agency shall review the undue hardship waiver and the actions of the individual to try to regain the transferred assets. The time period for the review may not exceed six months. Upon review, the agency shall decide whether:

(a) the individual must take additional steps and whether undue hardship still exists, in which case the agency shall notify the individual of the continuation of undue hardship and the need to take additional steps to recover the assets;

(b) the individual has taken all reasonable steps without success, in which case the agency shall notify the individual that it requires no further action. If the individual continues to meet eligibility criteria, the eligibility agency may not apply the penalty period; or

(c) the individual has not taken all reasonable steps, in which case the eligibility agency shall discontinue the undue hardship waiver. The eligibility agency shall then apply the penalty period and the individual is responsible to repay Medicaid for services and benefits the individual received during the months in which the undue hardship waiver was in place.

(14) Based on a review of the facts about what happened to the assets, whether the individual has taken reasonable steps to recover or regain the assets, the results of those steps, and the likelihood that additional steps will prove unsuccessful or too costly, the eligibility agency may determine that the individual cannot recover or regain the transferred resource. If the agency decides the assets cannot be recovered and that applying the penalty period may result in undue hardship, the agency may not apply a penalty period or shall end a penalty period that has already begun.

(15) The eligibility agency shall base its decision that undue hardship exists upon the medical condition and the financial situation of the individual. The agency shall compare the income and resources of the individual, individual's spouse, and parents of an unemancipated individual to the cost of providing medical care and daily living expenses to decide whether the financial situation creates an undue hardship. The agency shall send written notice of its decision on the undue hardship request. The individual has 90 days from the date printed on the notice of decision to file a request for a fair hearing.

(16) The eligibility agency shall consider the portion of an irrevocable burial trust that exceeds $7,000 a transfer of resources. The agency shall deduct the value of any fully paid burial plot from the burial trust first before determining the transferred amount.

R414-305-10. Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual Resource Provisions.

(1) To determine eligibility for Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals, the eligibility agency shall apply the resource limit defined in 42 U.S.C. Sec.1396d(p)(1)(C).

(2) The eligibility agency shall determine countable resources in accordance with the provisions of Section R414-305-3.

R414-305-11. Treatment of Annuities.

(1) An individual must report any annuities in which either the individual or the individual's spouse has any interest at application for Medicaid, at each review, and as part of the change reporting requirements. Parents of a minor individual must report any annuities in which the child or either of the parents has an interest.

(2) For annuities purchased after February 7, 2006, in which the individual or spouse has an interest, the provisions in 42 U.S.C. 1396p(c) apply. The eligibility agency shall treat annuities purchased after February 7, 2006, which do not meet the requirements of 42 U.S.C. 1396p(c), as a transfer of assets for less than fair market value.

(3) With the exception of annuities that meet the criteria in Subsection R414-305-11(4), the eligibility agency shall count annuities in which the individual, the individual's spouse or a minor individual's parent has an interest as an available resource to determine Medicaid eligibility, whether they are irrevocable or non-assignable. The agency shall presume that a market exists to purchase annuities or the stream of income from annuities, which make them available resources. The individual may rebut the presumption that the annuity may be sold by providing evidence that the individual has been rejected by several entities in the business of purchasing annuities or the revenue stream from annuities, in which case, the agency may not consider the annuity as an available resource.

(4) For individuals eligible under the aged, blind, or disabled category of Medicaid, the eligibility agency shall exclude an annuity from countable resources in the form of the periodic payment if it meets the following requirements.

(a) The annuity is either an individual retirement annuity according to Section 408(b) of the Internal Revenue Code (IRC) of 1986 or a deemed Individual Retirement Account under a qualified employer plan according to Section 408(q) of the IRC; or

(b) The annuity is purchased with the proceeds from one of the following:

(i) As described in Sections 408(a), (c), or (p) of the IRC, a traditional IRA, accounts or trusts which are treated as a traditional IRA, or a simplified retirement account;

(ii) A simplified employee pension (Section 408(p) of the IRC); or

(iii) A Roth IRA (Section 408A of the IRC); and

(c) The annuity is irrevocable and non-assignable, the individual who was the owner of the retirement account or plan is receiving equal periodic payments at least quarterly with no deferral or balloon payments, and the scheduled payout period is actuarially sound based on the individual's life expectancy.

(d) If the individual purchases or annuitizes the annuities after February 7, 2006, the annuities must name the State as the preferred remainder beneficiary in the first position upon the individual's death, or as secondary remainder beneficiary after a surviving spouse or minor or disabled child.

(5) For family-related medically needy Medicaid programs, the eligibility agency shall count all annuities as resources if the individual can access the funds, even if the annuities qualify as retirement funds or plans.

(6) Annuities purchased on or after February 8, 2006, in which the individual or the spouse has an interest are a transfer of assets for less than fair market value unless the annuity names the State as the preferred remainder beneficiary in the first position, or in the second position after a surviving spouse, or a surviving minor or disabled child, up to the amount of medical assistance paid on behalf of the institutionalized individual.

(a) The State shall give individuals who have purchased annuities before applying for long-term care Medicaid, 30 days to request the issuing company to name the State as the preferred remainder beneficiary and to verify that fact to Medicaid.

(b) The individual must verify to the eligibility agency that the change in beneficiary has been made by the date requested by the agency.

(c) If the change of beneficiary is not completed and verified, the annuities are a transfer of resources and the eligibility agency shall apply the penalty period. If the eligibility agency has approved institutional Medicaid coverage pending verification, Medicaid coverage for long-term care ends and the penalty period begins the day after the closure date.

(7) The eligibility agency shall treat an annuity purchased before February 8, 2006, as an annuity purchased on or after February 8, 2006, if the individual or spouse take any actions that change the course of payments to be made or the treatment of the income or principal of the annuity. These actions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract, or other similar actions. Routine changes and automatic events that do not involve an action or decision from the individual or spouse do not cause an annuity purchased before February 8, 2006, to be treated as one purchased on or after February 8, 2006.

(8) If a penalty period for a transfer of assets begins because the individual or the individual's spouse has not changed an annuity to name the State as the preferred remainder beneficiary of the annuity, the penalty period for a transfer does not end until the individual completes and verifies the change of beneficiary to the eligibility agency. The eligibility agency may not rescind the penalty period.

(9) If the individual or spouse does not provide all information about annuities for which they have an interest by the requested due date, the eligibility agency shall deny the application. The individual may reapply, but may not protect the original application date.

(10) The issuer of the annuity shall inform the eligibility agency of any change in the amount of income or principal being withdrawn from the annuities, any change of beneficiaries, or any sale or transfer of the annuity. The issuer of the annuity shall also inform the agency if a surviving spouse or a surviving minor or disabled child attempts to transfer the annuity or any portion of the annuity to someone other than the agency.

KEY: Medicaid, resources
Date of Enactment or Last Substantive Amendment: September 13, 2017
Notice of Continuation: January 8, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; Pub. L. No. 111-148

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-306**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

General Information

2. Rule catchline:
Program Benefits and Date of Eligibility
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
42 U.S.C. 1396d(p) specifies required services for qualified Medicare beneficiaries, specified low-income beneficiaries, and qualifying individuals, and Section 26-18-3 requires the Department to implement program benefits by administrative rule.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it establishes effective dates of eligibility and benefits available to qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, and qualifying individuals. It will also continue this rule because it requires program coordination to inform members of available benefits, refers members to available transportation services, and spells out criteria for supplemental payments to institutionalized individuals.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/04/2023
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-306. Program Benefits and Date of Eligibility.
R414-306-1. Medicaid Benefits and Coordination with Other Programs.

(1) The Department provides medical benefits to Medicaid recipients as outlined in Section R414-1-6.

(2) The Department elects to coordinate Medicaid with Medicare Part B for all Medicaid recipients.

(3) The Department must inform applicants about the Child Health Evaluation and Care (CHEC) program. By signing the application form the client acknowledges receipt of CHEC program information.

(4) The Department must coordinate with the Children's Health Insurance Program to assure the enrollment of eligible children.

(5) The Department must coordinate with the Women, Infants and Children Program to provide information to applicants and recipients about the availability of services.

R414-306-2. QMB, SLMB, and QI Benefits.

The Department shall provide the services outlined under 42 U.S.C. 1396d(p) and 42 U.S.C. 1396u-3 for Qualified Medicare Beneficiaries.

(2) The Department shall provide the benefits outlined under 42 U.S.C. 1396d(p)(3)(ii) for Specified Low-Income Medicare Beneficiaries and Qualifying Individuals. Benefits for Qualifying Individuals are subject to the provisions of 42 U.S.C. 1396u-3.

(3) The Department does not cover premiums for enrollment with any health insurance plans except for Medicare.

R414-306-3. Qualified Medicare Beneficiary Date of Entitlement.

(1) Eligibility for the Qualified Medicare Beneficiary (QMB) program begins the first day of the month after the month the Medicaid eligibility agency determines that the individual is eligible, in accordance with the requirements of 42 U.S.C. 1396a(e)(8).

(2) There is no provision for retroactive QMB assistance.

R414-306-4. Effective Date of Eligibility.

(1) Subject to the exceptions in Subsection R414-306-4(3), eligibility for any Medicaid program, and for the Specified Low-income Medicare Beneficiary (SLMB) or Qualified Individual (QI) programs begins the first day of the application month if the individual is determined to meet the eligibility criteria for that month.

(2) An applicant for Medicaid, SLMB or QI benefits may request medical coverage for the retroactive period. The retroactive period is the three months immediately preceding the month of application.

(a) An applicant may request coverage for one or more months of the retroactive period.

(b) Subject to the exceptions in Subsection R414-306-4(3), eligibility for retroactive medical coverage begins no earlier than the first day of the month that is three months before the application month.

(c) The applicant must receive medical services during the retroactive period and be determined eligible for the month he receives services.

(3) To determine the date eligibility for medical assistance may begin for any month, the following requirements apply:

(a) Eligibility of an individual cannot begin any earlier than the date the individual meets the state residency requirement defined in Section R414-302-4;

(b) Eligibility of a qualified alien subject to the five-year bar on receiving regular Medicaid services cannot begin earlier than the date that is five years after the date the person became a qualified alien, or the date the five-year bar ends due to other events defined in statute;

(c) Eligibility of a qualified alien not subject to the five-year bar on receiving regular Medicaid services can begin no earlier than the date the individual meets qualified alien status.

(d) An individual who is ineligible for Medicaid while residing in a public institution or an Institution for Mental Disease (IMD) may become eligible on the date the individual is no longer a resident of either one of these institutions. If an individual is under the age of 22 and is a resident of an IMD, the individual remains a resident of the IMD until he is unconditionally released.

(4) If an applicant is not eligible for the application month, but requests retroactive coverage, the agency will determine eligibility for the retroactive period based on the date of that application.

(5) The eligibility agency shall determine retroactive eligibility by using the eligibility criteria in effect during the retroactive month. Modified Adjusted Gross Income (MAGI) methodology is effective only on or after January 1, 2014, and the eligibility agency may not apply MAGI methodology before that date.

(6) The agency may use the same application to determine eligibility for the month following the month of application if the applicant is determined ineligible for both the retroactive period and the application month. In this case, the application date changes to the date eligibility begins. The retroactive period associated with the application changes to the three months preceding the new application date.

(7) The effective date of eligibility is January 1, 2014, for applicants who file for eligibility from October 1, 2013, through December 31, 2013, and are not found eligible using 2013 eligibility criteria, but are found eligible for a coverage group using MAGI methodology.

(8) Medicaid eligibility for certain services begins when the individual meets the following criteria:

(a) Eligibility for coverage of institutional services cannot begin before the date that the individual has been admitted to a medical institution and meets the level of care criteria for admission. The medical institution must provide the required admission verification to the Department within the time limits set by the Department in Rule R414-501. Medicaid eligibility for institutional services does not begin earlier than the first day of the month that is three months before the month of application for Medicaid coverage of institutional services.

(b) Eligibility for coverage of home and community-based services under a Medicaid waiver cannot begin before the first day of the month the client is determined by the case management agency to meet the level of care criteria and home and community-based services are scheduled to begin within the month. The case management agency must verify that the individual meets the level of care criteria for waiver services. Medicaid eligibility for waiver services does not begin earlier than the first day of the month that is three months before the month of application for Medicaid coverage of waiver services.

(9) An individual determined eligible for QI benefits in a calendar year is eligible to receive those benefits throughout the remainder of the calendar year, if the individual continues to meet the eligibility criteria and the program still exists. Receipt of QI benefits in one calendar year does not entitle the individual to QI benefits in any succeeding year.

(10) After being approved for Medicaid, a client may later request coverage for the retroactive period associated with the approved application if the following criteria are met:

(a) The client did not request retroactive coverage at the time of application; and

(b) The agency did not make a decision about eligibility for medical assistance for that retroactive period; and

(c) The client states that he received medical services and provides verification of his eligibility for the retroactive period.

(11) The Department may not provide retroactive coverage if a client requests coverage for the retroactive period associated with a denied application after the date of denial. The client, however, may reapply and the eligibility agency may consider a new retroactive coverage period based on the new application date.

R414-306-5. Medical Transportation.

The Medical Transportation program provides medical transportation services for Medicaid recipients in accordance with the Medical Transportation Utah Medicaid Provider Manual, as incorporated into Section R414-1-5.

R414-306-6. State Supplemental Payments for Institutionalized SSI Recipients.

(1) The Department incorporates by reference Section 1616(a) through (d) of the Compilation of the Social Security Laws, January 1, 2009 ed.

(2) A State Supplemental payment equal to $15 shall be paid to a resident of a medical institution who receives a Supplemental Security Income (SSI) payment.

(3) Recipients must be eligible for Medicaid benefits to receive the State Supplemental payment.

(4) Recipients are eligible to receive the $15 State Supplemental payment beginning with the first month that their SSI assistance is reduced to $30 a month because they stay in an institution and they are eligible for Medicaid.

(5) The State Supplemental payment terminates effective the month the recipient no longer meets the eligibility criteria for receiving such supplemental payment.

KEY: effective date, program benefits, medical transportation
Date of Enactment or Last Substantive Amendment: August 1, 2015
Notice of Continuation: January 8, 2018
Authorizing, and Implemented or Interpreted Law: 26-18

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-308**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

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

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

General Information

2. Rule catchline:

Application, Eligibility Determinations, Improper Medical Assistance, and Suspension of Benefits

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

Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules, and 42 CFR 435.952 sets forth agency procedures for uses and requests of additional information when making eligibility determinations.

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

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

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

The Department will continue this rule because it implements procedures for application, establishes protocol for verifications and exchanges, specifies procedures for eligibility decisions and periods of review, sets forth requirements for change reporting, spells out protocols for case closures and redeterminations, outlines member and agency responsibilities in cases of improper medical coverage, and assures continued coverage through the duration of the public health emergency for individuals who are eligible.

Agency Authorization Information

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

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	01/04/2023

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

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-308. Application, Eligibility Determinations, Improper Medical Assistance, and Suspension of Benefits.
R414-308-1. Authority and Purpose.

(1) This rule is authorized by Section 26-18-3.

(2) The purpose of this rule is to establish requirements for medical assistance applications, eligibility decisions and reviews, eligibility period, verifications, change reporting, notification and improper medical assistance for Medicaid and Medicare cost sharing programs.

R414-308-2. Definitions.

(1) The definitions in Rules R414-1 and R414-301 apply to this rule.

(2) In addition, the following definitions apply:

(a) "Due date" means the date that a recipient is required to report a change or provide requested verification to the eligibility agency.

(b) "Eligibility review" means a process by which the eligibility agency reviews current information about a recipient's circumstances to determine whether the recipient is still eligible for medical assistance.

(c) "Open enrollment" means a period of time when the eligibility agency accepts applications.

(d) "Suspension of Benefits" means a period of time when an incarcerated individual is still Medicaid eligible, but loses Medicaid coverage.

R414-308-3. Application and Signature.

(1) The Department shall comply with the requirements in 42 CFR 435.907, concerning the application for medical assistance.

(a) The applicant or authorized representative must complete and sign the application under penalty of perjury. If an applicant cannot write, the applicant must mark on the application form and have at least one witness to the signature.

(i) An electronic signature is legal in accordance with Section 46-4-201.

(ii) An electronic signature must be retrievable as evidence of the individual's case record.

(b) A representative may apply on behalf of an individual. A representative may be a legal guardian, a person holding a power of attorney, a representative payee or other responsible person acting on behalf of the individual. In this case, the eligibility agency may send notices, requests and forms to both the individual and the individual's representative, or to just the individual's representative. The eligibility agency may assign someone to act as the authorized representative when the individual requires help to apply and cannot appoint a representative.

(c) If the Division of Child and Family Services (DCFS) has custody of a child and the child is placed in foster care, DCFS must complete the application. DCFS determines eligibility for the child pursuant to a written agreement with the Department. DCFS also determines eligibility for children placed under a subsidized adoption agreement. The Department does not require an application for Title IV-E eligible children.

(2) The application date for medical assistance is the date the eligibility agency receives the application during normal business hours on a week day that does not include Saturday, Sunday, or a state holiday except as described in Subsection (2):

(a) When the individual applies through the federally facilitated marketplace (FFM) and the application is transferred from the FFM for a Medicaid eligibility determination, the date of application is the date the individual applies through the FFM;

(b) If the application is delivered to the eligibility agency after the close of business, the date of application is the next business day;

(c) If the applicant delivers the application to an outreach location during normal business hours, the date of application is that business day when outreach staff is available to receive the application. If the applicant delivers the application to an outreach location on a non-business day or after normal business hours, the date of application is the last business day that a staff person from the eligibility agency is available at the outreach location to receive or pick up the application;

(d) When the eligibility agency receives application data transmitted from the Social Security Administration (SSA) pursuant to the requirements of 42 U.S.C. Sec. 1320b-14(c), the eligibility agency shall use the date that the individual submits the application for the low-income subsidy to the SSA as the application date for Medicare cost-sharing programs. The application processing period for the transmitted data begins on the date the eligibility agency receives the transmitted data. The transmitted data meets the signature requirements for applications for Medicare cost-sharing programs;

(e) If an application is filed through the "myCase" system, the date of application is the date the application is submitted to the eligibility agency online.

(3) The eligibility agency shall accept a signed application that an applicant sends by facsimile as a valid application.

(4) If an applicant submits an unsigned or incomplete application form to the eligibility agency, the eligibility agency shall notify the applicant to sign and complete the application no later than the last day of the application processing period. The eligibility agency shall send a signature page to the applicant and give the applicant at least 10 days to sign and return the signature page. When the application is incomplete, the eligibility agency shall notify the applicant of the need to complete the application and offer ways to complete the application.

(a) The date of application for an incomplete or unsigned application form is the date the eligibility agency receives the application if the agency receives a signed signature page and completed application within the application processing period.

(b) If the eligibility agency does not receive a signed signature page and completed application form within the application processing period, the application is void and the eligibility agency shall send a denial notice to the applicant.

(c) If the eligibility agency receives a signed signature page and completed application within 30 calendar days after the notice of denial date, the date of receipt is the new application date and the Subsection (2) applies.

(d) If the eligibility agency receives a signed signature page and completed application more than 30 calendar days after it sends the denial notice, the applicant must reapply by completing and submitting a new application form. The new application date is determined in accordance with this rule.

(5) The eligibility agency treats the following situations as a new application without requiring a new application form. The application date is the day the eligibility agency receives the request or verification from the recipient. The effective date of eligibility for these situations depends on the rules for the specific program.

(a) A household with an open medical assistance case must ask to add a new household member by contacting the eligibility agency.

(b) The eligibility agency shall end medical assistance when the recipient fails to return requested verification, and the recipient must provide requested verification to the eligibility agency before the end of the calendar month that follows the closure date. The eligibility agency waives the requirement for the open enrollment period during that calendar month for programs subject to open enrollment.

(c) The eligibility agency shall end a medical assistance program due to an incomplete review, and the recipient must respond to the review request within the three calendar months that follow the closure date.

(d) Except for Targeted Adult Medicaid and Utah's Premium Partnership for Health Insurance (UPP) that are subject to open enrollment periods, the eligibility agency shall deny an application when the applicant fails to provide requested verification, but provides requested verification within 30 calendar days of the denial notice date. The new application date is the date the eligibility agency receives requested verification and the retroactive period is based on that date. The eligibility agency does not act if it receives verification more than 30 calendar days after it denies the application. The recipient must complete a new application to reapply for medical assistance.

(e) For Targeted Adult Medicaid and UPP applicants, the eligibility agency shall deny an application when the applicant fails to provide requested verification, but provides requested verification within 30 calendar days of the denial notice date and the eligibility agency has not stopped the open enrollment period. If the eligibility agency has stopped enrollment, the applicant must wait for an open enrollment period to reapply.

(6) For an individual who applies for and is found ineligible for Medicaid from October 1, 2013, through December 31, 2013, the eligibility agency shall redetermine eligibility under the policies that become effective January 1, 2014, using the modified adjusted gross income (MAGI)-based methodology without requiring a new application.

(a) Medicaid eligibility may begin no earlier than January 1, 2014, for an individual who becomes eligible using the MAGI-based methodology.

(b) For applications received on or after January 1, 2014, the eligibility agency shall apply the MAGI-based methodology first to determine Medicaid eligibility.

(c) The eligibility agency shall determine eligibility for other Medicaid programs that do not use MAGI-based methodology if the individual meets the categorical requirements of these programs, which may include a medically needy eligibility group for individuals found ineligible using the MAGI-based methodology.

(7) If a medical assistance case closes for one or more calendar months, the recipient must complete a new application form to reapply, except as defined in Subsection R414-308-6(7).

(8) An individual determined eligible for a presumptive eligibility period must file an application for medical assistance with the eligibility agency in accordance with the requirements of Sections 1920, 1920A, and 1920B of the Social Security Act.

(9) The eligibility agency shall process low-income subsidy application data transmitted from SSA in accordance with 42 U.S.C. Sec. 1320b-14(c) as an application for Medicare cost-sharing programs. The eligibility agency shall take appropriate steps to gather the required information and verification from the applicant to determine the applicant's eligibility.

(a) Data transmitted from SSA is not an application for Medicaid.

(b) An individual who wants to apply for Medicaid when contacted for information to process the application for Medicare cost-sharing programs must complete and sign a Department-approved application form for medical assistance. The date of application for Medicaid is the date the eligibility agency receives the application for Medicaid.

R414-308-4. Verification of Eligibility and Information Exchange.

(1) The Department adopts and incorporates by reference 42 CFR 435.945, 435.948, 435.949, 435.952, and 435.956, October 1, 2012 ed.

(a) The Department may seek approval from the Secretary in accordance with 42 CFR 435.945(k) to use alternative electronic data sources in lieu of using the data available from the federal data hub.

(b) Medical assistance applicants and recipients must provide identifying information that the eligibility agency needs to complete electronic data matches.

(c) The eligibility agency may request verification from applicants and recipients in accordance with the agency's verification plan that is necessary to determine eligibility.

(2) Medical assistance applicants and recipients must verify all eligibility factors requested by the eligibility agency to establish or to redetermine eligibility when the information cannot be verified through electronic data matches, or when the electronic data match information is not reasonably compatible with the client provided information.

(a) The eligibility agency shall provide the applicant or recipient a written request of the needed verification.

(b) The applicant or recipient has at least ten calendar days from the date that the eligibility agency gives or sends the verification request to provide verification.

(c) The due date for returning verification, forms or information requested by the eligibility agency is the close of business on the date that the eligibility agency sets as the due date in a written request.

(d) An applicant must provide all requested verification before the close of business on the last day of the application period. If the last day of the application processing period is a non-business day, the applicant or recipient has until the close of business on the next business day to return verification.

(e) The eligibility agency shall allow the applicant or recipient more time to provide verification if he requests more time by the due date. The eligibility agency shall set a new due date based on what the applicant or recipient needs to do to obtain the verification and whether he shows a good faith effort to obtain the verification.

(f) If an applicant or recipient does not provide verification by the due date and does not contact the eligibility agency to ask for

more time to provide verification, the eligibility agency shall deny the application or review, or end eligibility.

(g) If a due date falls on a non-business day, the due date is the close of business on the next business day.

(3) The eligibility agency must receive verification of an individual's income, both unearned and earned. To be eligible under the Medicaid Work Incentive program, the eligibility agency may require proof such as paycheck stubs showing deductions of FICA tax, self-employment tax filing documents, or for newly self-employed individuals who have not filed tax forms yet, a written business plan and verification of gross receipts and business expenses, to verify that the income is earned income.

(4) If an applicant's citizenship and identity do not match through the Social Security electronic match process and the eligibility agency cannot resolve this inconsistency, the eligibility agency shall require the applicant to provide verification of his citizenship and identity in accordance with 42 U.S.C. 1396a(ee)(1)(B).

(a) The individual must provide verification to resolve the inconsistency or provide original documentation to verify his citizenship and identity within 90 days of the request.

(b) The eligibility agency shall continue to provide medical assistance during the 90-day period if the individual meets all other eligibility criteria.

(c) If the individual fails to provide verification, the eligibility agency shall end eligibility within 30 days after the 90-day period. The eligibility agency may not extend or repeat the verification period.

(d) An individual who provides false information to receive medical assistance is subject to investigation of Medicaid fraud and penalties as outlined in 42 CFR 455.13 through 455.23.

R414-308-5. Eligibility Decisions or Withdrawal of an Application.

(1) The Department adopts and incorporates by reference 42 CFR 435.911, 435.912 and 435.919, October 1, 2012 ed., regarding eligibility determinations and timely determinations. The eligibility agency shall provide proper notice about a recipient's eligibility, changes in eligibility, and the recipient's right to request a fair hearing in accordance with the provisions of 78 FR 42303, which is incorporated by reference and 42 CFR 431.206, 431.210, 431.211, 431.213, 431.214, October 1, 2012 ed., which are incorporated by reference.

(2) The eligibility agency shall extend the time limit if the applicant asks for more time to provide requested information before the due date. The eligibility agency shall give the applicant at least ten more days after the original due date to provide verifications upon the applicant's request. The eligibility agency may allow a longer period of time for the recipient to provide verifications if the agency determines that the delay is due to circumstances beyond the recipient's control.

(3) If an individual who is determined presumptively eligible files an application for medical assistance in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act, the eligibility agency shall continue presumptive eligibility until it makes an eligibility decision based on that application. The filing of additional applications by the individual does not extend the presumptive eligibility period.

(4) An applicant may withdraw an application for medical assistance any time before the eligibility agency makes an eligibility decision. An individual requesting an assessment of assets for a married couple under 42 U.S.C. 1396r-5 may withdraw the request any time before the eligibility agency completes the assessment.

R414-308-6. Eligibility Period and Reviews.

(1) The eligibility period begins on the effective date of eligibility as defined in Section R414-306-4, which may be after the first day of a month, subject to the following requirements.

(a) If a recipient must pay one of the following fees to receive Medicaid, the eligibility agency shall determine eligibility and notify the recipient of the amount owed for coverage. The eligibility agency shall grant eligibility when it receives the required payment, or in the case of a spenddown or cost-of-care contribution for waivers, when the recipient sends proof of incurred medical expenses equal to the payment. The fees a recipient may owe include:

(i) a spenddown of excess income for medically needy Medicaid coverage;

(ii) a Medicaid Work Incentive (MWI) premium; or

(iii) a cost-of-care contribution for home and community-based waiver services.

(b) A required spenddown, MWI premium, or cost-of-care contribution is due each month for a recipient to receive Medicaid coverage.

(c) The recipient must make the payment or provide proof of medical expenses within 30 calendar days from the mailing date of the application approval notice, which states how much the recipient owes.

(d) For ongoing months of eligibility, the recipient has until the close of business on the tenth day of the month after the benefit month to meet the spenddown or the cost-of-care contribution for waiver services, or to pay the MWI premium. If the tenth day of the month is a non-business day, the recipient has until the close of business on the first business day after the tenth. Eligibility begins on the first day of the benefit month once the recipient meets the required payment. If the recipient does not meet the required payment by the due date, the recipient may reapply for retroactive benefits if that month is within the retroactive period of the new application date.

(e) A recipient who lives in a long-term care facility and owes a cost-of-care contribution to the medical facility must pay the medical facility directly. The recipient may use unpaid past medical bills, or current incurred medical bills other than the charges from the medical facility, to meet some or all of the cost-of-care contribution subject to the limitations in Section R414-304-9. An unpaid cost-of-care contribution is not allowed as a medical bill to reduce the amount that the recipient owes the facility.

(f) Even when the eligibility agency does not close a medical assistance case, no eligibility exists in a month for which the recipient fails to meet a required spenddown, MWI premium, or cost-of-care contribution for home and community-based waiver services.

(g) The eligibility agency shall continue eligibility for a resident of a nursing home even when an eligible resident fails to pay the

nursing home the cost-of-care contribution. The resident, however, must continue to meet all other eligibility requirements.

(2) The eligibility period ends on:

(a) the last day of the month in which the eligibility agency determines that the recipient is no longer eligible for medical assistance and sends proper closure notice;

(b) the last day of the month in which the eligibility agency sends proper closure notice when the recipient fails to provide required information or verification to the eligibility agency by the due date;

(c) the last day of the month in which the recipient asks the eligibility agency to discontinue eligibility, or if benefits have been issued for the following month, the end of that month;

(d) for time-limited programs, the last day of the month in which the time limit ends;

(e) for the pregnant woman program, the last day of the month which is at least 60 days after the date the pregnancy ends, except that for pregnant woman coverage for emergency services only, eligibility ends on the last day of the month in which the pregnancy ends; or

(f) the date the individual dies.

(3) A presumptive eligibility period begins on the day the qualified entity determines an individual to be presumptively eligible. The presumptive eligibility period shall end on the earlier of:

(a) the day the eligibility agency makes an eligibility decision for medical assistance based on the individual's application when that application is filed in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act; or

(b) in the case of an individual who does not file an application in accordance with the requirements of Sections 1920 and 1920A of the Social Security Act, the last day of the month that follows the month in which the individual becomes presumptively eligible.

(4) For an individual selected for coverage under the Qualified Individuals Program, the eligibility agency shall extend eligibility through the end of the calendar year if the individual continues to meet eligibility criteria and the program still exists.

(5) The eligibility agency shall complete a periodic review of a recipient's eligibility for medical assistance in accordance with the requirements of 42 CFR 435.916, October 1, 2013 ed., which the Department adopts and incorporates by reference. The Department elects to conduct reviews for non-MAGI-based coverage groups in accordance with 42 CFR 435.916(a)(3) if eligibility cannot be renewed in accordance with 42 CFR 435.916(a)(2). The eligibility agency shall review factors that are subject to change to determine if the recipient continues to be eligible for medical assistance.

(6) For non-MAGI-based coverage groups, the eligibility agency may complete an eligibility review more frequently when it:

(a) has information about anticipated changes in the recipient's circumstances that may affect eligibility;

(b) knows the recipient has fluctuating income;

(c) completes a review for other assistance programs that the recipient receives; or

(d) needs to meet workload demands.

(7) If a recipient fails to respond to a request for information to complete the review, the eligibility agency shall end eligibility effective at the end of the review month and send proper notice to the recipient.

(a) If the recipient responds to the review or reapplies within three calendar months of the review closure date, the eligibility agency shall consider the response to be a new application without requiring the client to reapply. The application processing period shall apply for the new request for coverage.

(b) If the recipient becomes eligible based on this reapplication, the recipient's eligibility becomes effective the first day of the month after the closure date if verification is provided timely. If the recipient fails to return verification timely or if the recipient is determined to be ineligible, the eligibility agency shall send a denial notice to the recipient.

(c) The eligibility agency may not continue eligibility while it makes a new eligibility determination.

(8) If the eligibility agency sends proper notice of an adverse decision in the review month, the agency shall change eligibility for the following month.

(9) If the eligibility agency does not send proper notice of an adverse change for the following month, the agency shall extend eligibility to the following month. Upon completing an eligibility determination, the eligibility agency shall send proper notice of the effective date of any adverse decision.

(10) If the recipient responds to the review in the review month and the verification due date is in the following month, the eligibility agency shall extend eligibility to the following month. The recipient must provide all verification by the verification due date.

(a) If the recipient provides all requested verification by the verification due date, the eligibility agency shall determine eligibility and send proper notice of the decision.

(b) If the recipient does not provide all requested verification by the verification due date, the eligibility agency shall end eligibility effective the end of the month in which the eligibility agency sends proper notice of the closure.

(c) If the recipient returns all verification after the verification due date and before the effective closure date, the eligibility agency shall treat the date that it receives the verification as a new application date. The agency shall then determine eligibility and send notice to the recipient.

(11) The eligibility agency shall provide ten-day notice of case closure if the recipient is determined ineligible or if the recipient fails to provide all verification by the verification due date.

(12) The eligibility agency may not extend coverage under certain medical assistance programs in accordance with state and federal law. The agency shall notify the recipient before the effective closure date.

(a) If the eligibility agency determines that the recipient qualifies for a different medical assistance program, the agency shall notify the recipient. Otherwise, the agency shall end eligibility when the permitted time period for such program expires.

(b) If the recipient provides information before the effective closure date that indicates that the recipient may qualify for another medical assistance program, the eligibility agency shall treat the information as a new application. If the recipient contacts the eligibility

agency after the effective closure date, the recipient must reapply for benefits.

R414-308-7. Change Reporting and Benefit Changes.

(1) A recipient must report to the eligibility agency reportable changes as defined in Section R414-301-2 within 10 calendar days of the change.

(2) The eligibility agency shall:

(a) Act on the reported change; and

(b) Request verification from the recipient if the change cannot be verified through an electronic interface or other credible source.

(3) If verification is needed, the agency shall send a written request and give the recipient at least 10 calendar days from the notice date to respond.

(a) If the recipient does not provide verification by the due date, the agency shall end eligibility after the month in which proper notice is sent.

(b) If the recipient provides verification by the due date, the agency shall re-determine eligibility.

(c) If the recipient provides verification during the month that follows the effective closure date, the eligibility agency shall treat the date as a new application date without requiring a new application.

(d) If the recipient does not provide verification by the end of the month that follows the effective closure date, the recipient must submit a new application.

(4) If the recipient does not provide verification, or a reported change does not affect all household members, the agency may only take action on those individuals who are affected by the change.

(5) If a due date falls on a non-business day, then the due date shall be the close of the next business day.

(6) If a change has an adverse effect on the recipient, the agency shall change eligibility after the month in which proper notice is sent.

(7) If the agency can verify that a change is timely, the change becomes effective on the first day of the month of report.

(8) If the agency cannot verify that a change is timely, the change becomes effective on the first day of the month in which the agency receives verification.

(9) If a recipient requests to add a new household member, the effective date of the change is the date of request, and the following provisions apply:

(a) The agency does not require a new application; and

(b) The applicant must meet all other eligibility requirements.

(10) An overpayment may occur if the recipient does not report changes timely, or if the recipient does not return verification by the verification due date.

(a) The eligibility agency shall determine whether an overpayment has occurred based on when the agency could have made the change if the recipient had reported the change on time or returned verification by the due date.

(b) If a recipient fails to report a change timely or return verification or forms by the due date, the recipient must repay all services and benefits paid by the Department for which the recipient is ineligible.

R414-308-8. Case Closure and Redetermination.

(1) The eligibility agency shall end medical assistance when the recipient requests the agency to close his case, when the recipient fails to respond to a request to complete the eligibility review, when the recipient fails to provide all verification needed to determine continued eligibility, or when the agency determines that the recipient is no longer eligible.

(2) If a recipient fails to complete the review process in accordance with Section R414-308-6, the eligibility agency shall close the case and notify the recipient.

(3) Before terminating a recipient's medical assistance, the eligibility agency shall determine whether the recipient is eligible for any other available medical assistance provided under Medicaid, the Medicare Cost Sharing programs, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), and Utah's Premium Partnership for Health Insurance (UPP).

(a) The eligibility agency may not require a recipient to complete a new application to make the redetermination. The agency, however, may request more information from the recipient to determine whether the recipient is eligible for other medical assistance programs. If the recipient does not provide the necessary information by the close of business on the due date, the recipient's medical assistance ends.

(b) When determining eligibility for other programs, the eligibility agency may only enroll an individual in a medical assistance program during an open enrollment period, or when that program allows a person who becomes ineligible for Medicaid to enroll during a period when enrollment is closed. Open enrollment applies only to the PCN and UPP programs.

(4) The eligibility agency shall comply with the requirements of 42 CFR 435.1200, regarding transfer of the electronic file for the purpose of determining eligibility for other insurance affordability programs.

R414-308-9. Improper Medical Coverage.

(1) Improper medical coverage occurs when:

(a) an individual receives medical assistance for which the individual is not eligible. This assistance includes benefits that an individual receives pending a fair hearing or during an undue hardship waiver when the individual fails to take actions required by the eligibility agency;

(b) an individual receives a benefit or service that is not part of the benefit package for which the individual is eligible;

(c) an individual pays too much or too little for medical assistance benefits; or

(d) the Department pays in excess or not enough for medical assistance benefits on behalf of an eligible individual.

(2) As applied in this section, services and benefits include amounts the Department pays on behalf of the recipient during the period in question and includes:

(a) premiums the recipient pays to any Medicaid health plan or managed care plan including any payments for administration costs, Medicare, and private insurance plans;

(b) payments for prepaid mental health services; and

(c) payments made directly to service providers or to the recipient.

(3) If the eligibility agency determines a recipient is ineligible for the services and benefits that the recipient receives, the recipient must repay to the Department any costs that result from the services and benefits.

(4) The eligibility agency shall reduce the amount the recipient must repay by the amount the recipient pays to the eligibility agency for a Medicaid spenddown, a cost-of-care contribution, or a Medicaid Work Incentive (MWI) premium for the month.

(5) If the recipient is eligible, but the overpayment is because the spenddown, the MWI premium, or the cost-of-care contribution is incorrect, the recipient must repay the difference between the correct amount the recipient should pay and the amount the recipient has paid.

(6) If the eligibility agency determines the recipient is ineligible due to having resources that exceed the resource limit, the recipient must pay the lesser of the cost of services or benefits that the recipient receives, or the difference between the recipient's highest amount of excess countable resources held during the overpayment period and the resource limit.

(7) A recipient may request a refund from the Department if the recipient believes that:

(a) the monthly spenddown, or cost-of-care contribution the recipient pays to receive medical assistance is less than what the Department pays for medical services and benefits for the recipient; or

(b) the amount the recipient pays in the form of a spenddown, an MWI premium, or a cost-of-care contribution for long-term care services exceeds the payment requirement.

(8) Upon receiving the request, the Department shall determine whether it owes the recipient a refund.

(a) In the case of an incorrect calculation of a spenddown, MWI premium, or cost-of-care contribution, the refundable amount is the difference between the incorrect amount the recipient pays to the Department for medical assistance and the correct amount the recipient should pay, less the amount the recipient owes the Department for any other past due, unpaid claims.

(b) If the spenddown or a cost-of-care contribution for long-term care exceeds medical expenditures, the refundable amount is the difference between the correct spenddown or cost-of-care contribution that the recipient pays for medical assistance and the amount the Department pays on behalf of the recipient for services and benefits, less the amount the recipient owes the Department for any other past due, unpaid claims. The Department shall issue the refund only after the 12-month time period that medical providers have to submit claims for payment.

(c) The Department may not issue a cash refund for any portion of a spenddown or cost-of- care contribution that is met with medical bills. Nevertheless, the Department may pay additional covered medical bills used to meet the spenddown or cost-of-care contribution equal to the amount of refund the Department owes the recipient, or apply the bill amount toward a future spenddown or cost-of-care contribution.

(9) A recipient who pays a premium for the MWI program may not receive a refund even when the Department pays for services that are less than the premium the recipient pays for MWI.

(10) If the cost-of-care contribution that a recipient pays a medical facility is more than the Medicaid daily rate for the number of days the recipient is in the medical facility, the recipient may request a refund from the medical facility. The Department shall refund the amount it owes the recipient only when the medical facility sends the excess cost-of-care contribution to the Department.

(11) If the sponsor of an alien does not provide correct information, the alien and the alien's sponsor are jointly liable for any overpayment of benefits. The Department shall recover the overpayment from both the alien and the sponsor.

R414-308-10. Suspension of Benefits.

Individuals who are inmates of a public institution will not be closed or denied Medicaid eligibility, but placed in a suspended status. The following apply to suspension of benefits:

(1) Suspension of benefits applies to all Medicaid coverage groups;

(2) All factors of eligibility must be met to be suspended;

(3) Reviews must be completed for all individuals in a suspended status, with the exception of an individual who is under 21 years of age, or eligible for the Former Foster Care program.

R414-308-11. Public Health Emergency Provisions.

(1) In accordance with the public health emergency declared by the Secretary of Health and Human Services on January 27, 2020, the Department shall comply with the provisions of the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116 127, Subsection 6008(b).

(a) The Department shall assure continued coverage through the duration of the emergency period for individuals who are eligible and enrolled on March 18, 2020, the date of enactment of Pub. L. No. 116 127, or who subsequently become eligible and enrolled in medical assistance during the emergency period and any extensions.

(b) In addition to terminating benefits when a beneficiary stops being a Utah resident or upon request by the beneficiary, coverage may only continue through the date of the beneficiary's death.

(2) During the public health emergency period, and any extensions, a hospital provider contracted to complete presumptive eligibility for Medicaid shall complete decisions for the uninsured testing group as defined in Section R414-303-13.

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