DMHF Rules Matrix 4-20-23

Rule Summary	Bulletin Publication	Effective
R414-100 Medicaid Primary Care Network Services (Rule Repeal); The Department will repeal this rule because the Primary Care Network (PCN) no longer exists under the Medicaid program.	**4-15-23**	**5-22-23**
R380-250 HIPAA Privacy Rule Implementation (Five-Year Review); The Department will continue this rule because it safeguards health information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and because it allows members to request and access their protected health information (PHI), request to amend or restrict PHI, request an accounting of disclosures, and to file a complaint over a HIPAA violation. The Department anticipates amending this rule due to changes following consolidation and the recodification of the Department's statute.	**5-1-23**	**4-10-23**
R382-1 Benefits and Administration (Five-Year Review); The Department will continue this rule because it sets forth eligibility requirements for children to receive CHIP coverage. The Department anticipates an amendment to this rule following the recodification of the Department's statute.	**5-1-23**	**4-6-23**
R382-10 Eligibility (Five-Year Review); The Department will continue this rule because it sets forth eligibility requirements for children to receive CHIP coverage. The Department anticipates an amendment to this rule following the recodification of the Department's statute.	**5-1-23**	**4-10-23**
R414-52 Optometry Services (Five-Year Review); The Department will continue this rule because it implements optometry services for Medicaid members as described in the Vision Care Services Provider Manual and in the Medicaid State Plan.	**5-1-23**	**4-6-23**
R414-53 Eyeglasses Services (Five-Year Review); The Department will continue this rule because it implements eyeglasses services for Medicaid members as described in the Vision Care Services Provider Manual and in the Medicaid State Plan.	**5-1-23**	**4-6-23**

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

NOTICE OF PROPOSED RULE		
TYPE OF RULE: Repeal		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-100**	**Filing ID: Office Use Only**

Agency Information

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

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

General Information

2. Rule or section catchline:

Medicaid Primary Care Network Services

3. Purpose of the new rule or reason for the change (Why is the agency submitting this filing?)**:**

The Department will repeal this rule because the Primary Care Network (PCN) no longer exists under the Medicaid program.

4. Summary of the new rule or change (What does this filing do? If this is a repeal and reenact, explain the substantive differences between the repealed rule and the reenacted rule)**:**

This rule is repealed in its entirety, and no longer necessary, because PCN no longer exists under the Medicaid program.

Fiscal Information

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

A) State budget:

There is no impact to the state budget because this repeal only reflects current policy, and does not affect current or future appropriations.

B) Local governments:

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

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

There is no impact on small businesses because this repeal only reflects current policy, and does not affect current or future appropriations.

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

There is no impact on non-small businesses because this repeal only reflects current policy, and does not affect current or future appropriations.

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

There is no impact on Medicaid providers and Medicaid members because this repeal only reflects current policy, and does not affect current or future appropriations.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs to a single Medicaid provider or to a Medicaid member because this repeal only reflects current policy, and does not affect current or future appropriations.

Regulatory Impact Table

Fiscal Cost	**FY2023**	**FY2024**	**FY2025**

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

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

The Executive Director of the Department of Health, Tracy S. Gruber, has reviewed and approved this fiscal analysis. Businesses will see neither costs nor revenue as this rule repeal only reflects current policy, and does not affect current or future appropriations.

Citation Information

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

Section 26B-1-204	Section 26-18-3	

Incorporations by Reference Information

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

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

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

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

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

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

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

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)

A) Comments will be accepted until:	05/15/2023

B) A public hearing (optional) will be held:		
On (mm/dd/yyyy)**:**	**At** (hh:mm AM/PM)**:**	**At** (place)**:**

9. This rule change MAY become effective on:	05/22/2023
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	mm/dd/yyyy

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

[~~R414-100. Medicaid Primary Care Network Services.~~

~~R414-100-1. Introduction and Authority.~~

~~This rule lists the services under the Medicaid Primary Care Network (PCN). The Primary Care Network is authorized by a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act effective January 1, 1999. This rule is authorized by Title 26, Chapter18, UCA.~~

~~R414-100-2. Definitions.~~

~~(1) "Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:~~

~~(a) placing the enrollee's health in serious jeopardy;~~

~~(b) serious impairment to bodily functions;~~

~~(c) serious dysfunction of any bodily organ or part; or~~

~~(d) death.~~

~~(2) "Emergency services" means:~~

~~(a) attention provided within 24 hours of the onset of symptoms or within 24 hours of diagnosis;~~

~~(b) for a condition that requires acute care, and is not chronic;~~

~~(c) reimbursed only until the condition is stabilized sufficient that the patient can leave the hospital emergency department; and~~

~~(d) is not related to an organ transplant procedure.~~

~~(2) "Outpatient" means an enrollee who receives services from a licensed outpatient care facility.~~

~~(3) "Primary care" means services to diagnose and treat illness and injury as well as preventive health care services. Primary care promotes early identification and treatment of health problems, which can help to reduce unnecessary complications of illness or injury and maintain or improve overall health status.~~

~~R414-100-3. Services Available.~~

~~(1) To meet the requirements of 42 CFR 431.107, the department contracts with each provider who furnishes services under the PCN.~~

~~(2) By signing a provider agreement with the department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.~~

~~(3) By signing an application for Medicaid coverage, the enrollee agrees that the department's obligation to reimburse for services is governed by contract between the department and the provider.~~

~~(4) Medical or hospital services for which providers are reimbursed under the PCN are generally limited by~~

federal guidelines as set forth under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

(5) The following services in the Medicaid Primary Care Network are available to those adults found eligible under Section 1931 of the federal Social Security Act (Aid to Families of Dependent Children adults and medically needy adults):

(a) emergency services only in a designated hospital emergency department;

(b) primary care physician services provided directly by licensed physicians or osteopaths, or by licensed certified nurse practitioners, or physician assistants under appropriate supervision of the physician or osteopath, but not including pregnancy related or mental health services by any of the listed providers;

(c) services associated with surgery or administration of anesthesia are physician services to be provided by physicians or licensed certified nurse anesthetists;

(d) laboratory and radiology services by licensed and certified providers;

(e) durable medical equipment, supplies and appliances used to assist the patient's medical recovery;

(f) preventive services, immunizations and health education methods and materials to promote wellness, disease prevention and manage illnesses;

(g) pharmacy services by a licensed pharmacy limited to four prescriptions per month, per client with no overrides or exceptions in the number of prescriptions;

(h) dental services are limited to examinations, cleanings, fillings, extractions, treatment of abscesses or infections and to be covered must be provided by a dentist in the office;

(i) transportation services limited to ambulance (ground and air) service for medical emergencies;

(j) interpretive services provided by contracting entities competent to provide medical translation services for people with limited English proficiency and interpretive services for the deaf; and

(k) vision services once every 12 months including an eye examination/refraction by a licensed ophthalmologists or optometrists, but not including the cost of glasses or other refractive device.

KEY: Medicaid, primary care network
Date of Enactment or Last Substantive Amendment: September 27, 2017
Notice of Continuation: May 5, 2017
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:	**R380-250**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Administration	
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:
HIPAA Privacy Rule Implementation
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, and Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it safeguards health information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and because it allows members to request and access their protected health information (PHI), request to amend or restrict PHI, request an accounting of disclosures, and to file a complaint over a HIPAA violation. The Department anticipates amending this rule due to changes following consolidation and the recodification of our Department's statute.

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

R380. Health, Administration.
R380-250. HIPAA Privacy Rule Implementation.
R380-250-1. Authority and Purpose.

(1) This rule implements provisions required by 45 CFR Part 164, subpart E, dealing with the treatment of certain individually identifiable health information held by the Department of Health.

(2) This rule is authorized by Utah Code Sections 26-1-5 and 26-1-17.

R380-250-2. Definitions.

As used in this rule:

(1) "Access" means an eligibility query either telephonically or electronically. This does not include direct access to databases.

(2) "Covered program" means the smallest agency or program unit within the Department responsible for carrying out a covered function as that term is used in 45 CFR 164.501.

(3) "HIPAA Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information found in 45 CFR Part 160 and Subparts A and E of Part 164.

(4) "Individual" means a natural person. In the case of a individual without legal capacity or a deceased person, the personal representative of the individual.

R380-250-3. General Compliance.

(1) This rule applies only to those functions of the Department that are covered functions as that term is used in 45 CFR Part 164.

(2) Covered programs shall comply with the privacy requirements of 45 CFR Part 164, Subpart E in dealing with individually identifiable health information and the subjects of that information.

R380-250-4. Changes to Rule.

The Department reserves the right to alter this rule and its notices of privacy practices required by the HIPAA Privacy Rule.

R380-250-5. Sanctions, Retaliation.

(1) An employee of a covered program may be disciplined for failure to comply with the HIPAA Privacy Rule requirements found in 45 CFR Part 164, Subpart E. Discipline may include termination and civil or criminal prosecution.

(2) An employee of a covered program may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for exercising any right established by the HIPAA Privacy Rule or for opposing in good faith any act or practice made unlawful by the HIPAA Privacy Rule.

R380-250-6. Waiver of Rights Prohibited.

A covered program may not require individuals to waive their rights under 45 CFR 160.306 or 45 CFR Part 164, Subpart E as a condition of the provision of treatment, payment, health plan enrollment, or eligibility for benefits.

R380-250-7. Complaints.

(1) An individual may seek a review of a covered program's policies and procedures or its compliance with such policies and procedures through informal contact with the covered program.

(2) An individual may file a formal complaint concerning a covered program's policies and procedures implementing 45 CFR Part 164, Subpart E or its compliance with such policies and procedures or the requirements of 45 CFR Part 164, Subpart E by filing with the Office of the Executive Director of the Department a request for program action meeting the requirements of the Utah Administrative Procedures Act.

R380-250-8. Right to Request Privacy Protection.

(1) An individual may request restrictions on use and disclosure of protected health information as permitted in 45 CFR 164.522 by submitting a written request to the designated privacy officer for the covered program.

(2) The decision whether to grant the request, documentation of any restrictions, alternate communication methods, and conditions on providing confidential communications shall be in accordance with 45 CFR 164.522.

R380-250-9. Individual Access to Protected Health Information.

(1) An individual may request access to protected health information as permitted in 45 CFR 164.524 by submitting a written request to the designated privacy officer for the covered program.

(2) The right to access, decision whether to grant access, review of denials, timeliness of responses, form of access, time and manner of access, documentation and other required responses shall be in accordance with 45 CFR 164.524.

R380-250-10. Amendment of Protected Health Information.

(1) An individual may request amendment to protected health information about that individual that the individual believes is incorrect as permitted in 45 CFR 164.526 by submitting a written request to the designated privacy officer for the covered program.

(2) The decision whether to grant the request, the time frames for action by the covered program, amendment of the record, requirements for denial, and acting on notices of amendment from third parties shall be in accordance with 45 CFR 164.526.

R380-250-11. Accounting for Disclosures.

(1) An individual may request an accounting of disclosures of protected health information as permitted in 45 CFR 164.528 by submitting a written request to the designated privacy officer for the covered program.

(2) The content of the accounting and the provision of the accounting, shall be in accordance with 45 CFR 164.528.

R380-250-12. Provider Notice of Privacy Practices.

A Medicaid provider or a Children's Health Insurance Program (CHIP) provider shall not access the Medicaid database or the CHIP

eligibility database, unless the provider's notice of privacy practices contains a statement that the provider either has, or may submit personally identifiable information about the patient to the Medicaid eligibility database or to the CHIP eligibility database.

KEY: HIPAA, privacy
Date of Enactment or Last Substantive Amendment: August 7, 2013
Notice of Continuation: April 10, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-1-17

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R382-1**	**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:
R382-1 Benefits and Administration
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, and Section 26-40-103 requires the Department to administer and implement by rule the Children's Health Insurance Program (CHIP).
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 benefits, limitations, enrollment, reimbursement, cost sharing, and the fair-hearing process under CHIP. The Department anticipates amending this rule to update any outdated citations following the recodification of the Department's statute.

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

R382. Health, Children's Health Insurance Program.
R382-1. Benefits and Administration.
R382-1-1. Authority and Purpose.

This rule implements the Children's Health Insurance Program under Title XXI of the Social Security Act, as adopted in the state under Title 26, Chapter 40, Utah Children's Health Insurance Act. It is authorized by Section 26-40-103.

R382-1-2. Definitions.

The definitions found in Title 26, Chapter 40, Utah Children's Health Insurance Act apply to this rule. The following definitions also apply.

(1) "Applicant" means a child under 19 years of age on whose behalf an application has been made for benefits under the Children's Health Insurance Program (CHIP), but who is not an enrollee.

(2) "CHIP" means the Children's Health Insurance Program.

(3) "CHIP Beneficiary" means a child under 19 years of age who is determined eligible for the Children's Health Insurance Program.

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

R382-1-3. Nature of Program and Benefits.

(1) CHIP provides reimbursement to medical providers for the services they give to a child who meets the eligibility and application requirements of Rule R382-10. CHIP provides limited benefits as described in this rule. The Department provides reimbursement coverage under the program only for benefits and levels of coverage for each program benefit:

(a) as provided in rule governing CHIP; and

(b) as described and limited in Section 6.2 of the State Plan for the Children's Health Insurance Program, April 17. 2009 ed., which is adopted and incorporated by reference.

(2) CHIP is not health insurance. A relationship with the Department as the insurer and the beneficiary as the insured does not exist under this program.

R382-1-4. Limitation of Abortion Benefits.

The Department may only cover abortion in accordance with 42 U.S.C. Sec. 1397ee.

R382-1-5. Providers.

The Department requires a child to enroll in one of the managed care organizations (MCO) that contracts with the Department under the program.

R382-1-6. Reimbursement.

(1) The Department shall reimburse only for benefits as limited in its contracts with the MCOs.

(2) Payment for services by the contracted MCO and the CHIP beneficiary co-payment, if any, constitutes full payment for services. A provider may not bill or collect any additional monies for services rendered.

R382-1-7. Cost Sharing.

A provider may require a CHIP beneficiary to pay a co-payment equal to that listed in Section 8 of the State Plan for the Children's Health Insurance Program, April 17, 2009 ed., which is adopted and incorporated by reference.

R382-1-8. Agency Conferences, Fair Hearings, and Appeals.

(1) A CHIP applicant or beneficiary may request an agency conference in accordance with Section R414-301-5 at any time to resolve a problem without requesting an agency action under the Utah Administrative Procedures Act (UAPA).

(2) The CHIP applicant or beneficiary, parent, legal guardian, or authorized representative may request an agency action, also called a fair hearing, if the individual disagrees with an agency decision regarding the individual's eligibility. The request for a fair hearing must be in accordance with Section R414-301-7.

(3) The Department of Workforce Services shall conduct fair hearings on eligibility in accordance with Section R414-301-7.

(4) If a CHIP beneficiary disagrees with a decision of the MCO regarding a covered benefit or service, the beneficiary may appeal the decision through the MCO.

(a) A CHIP beneficiary must exhaust grievance remedies with the MCO before the beneficiary requests an agency action from the Department.

(b) The CHIP beneficiary may file an appeal with the Department if the beneficiary disagrees with the MCO's resolution. The beneficiary must file the appeal within 60 days of the date that the MCO sends the resolution notice.

(c) The Department shall conduct a review of the MCO's decision in accordance with 42 CFR 438.408 and issue a final decision to the CHIP beneficiary and the MCO.

(d) The Department shall conduct all appeals in accordance with UAPA.

(e) The CHIP beneficiary may continue to receive benefits if the beneficiary meets the conditions of 42 CFR 438.420.

KEY: children's health benefits, fair hearings
Date of Last Change: July 1, 2022
Notice of Continuation: April 11, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40-103

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R382-10**	**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

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, and Section 26-40-103 requires the Department to administer and implement by rule the Children's Health Insurance Program (CHIP).

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 children to receive CHIP coverage. The Department anticipates an amendment to this rule following the recodification of our Department's statute.

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:**	

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

R382. Health, Children's Health Insurance Program.
R382-10. Eligibility.
R382-10-1. Authority.

(1) This rule is authorized by Title 26, Chapter 40.

(2) The purpose of this rule is to set forth the eligibility requirements for coverage under the Children's Health Insurance Program (CHIP).

R382-10-2. Definitions.

(1) The Department adopts and incorporates by reference the definitions found in Subsections 2110(b) and (c) of the Compilation of Social Security Laws, in effect January 1, 2015.

(2) The Department adopts the definitions in Section R382-1-2. In addition, the Department adopts the following definitions:

(a) "American Indian or Alaska Native" means someone having origins in any of the original peoples of North and South

America (including Central America) and who maintains tribal affiliation or community attachment.

(b) "Best estimate" means the eligibility agency's determination of a household's income for the upcoming eligibility period, based on past and current circumstances and anticipated future changes.

(c) "Children's Health Insurance Program" (CHIP) means the program for benefits under the Utah Children's Health Insurance Act, Title 26, Chapter 40.

(d) "Co-payment and co-insurance" means a portion of the cost for a medical service for which the enrollee is responsible to pay for services received under CHIP.

(e) "Due process month" means the month that allows time for the enrollee to return all verification, and for the eligibility agency to determine eligibility and notify the enrollee.

(f) "Eligibility agency" means the Department of Workforce Services (DWS) that determines eligibility for CHIP under contract with the Department.

(g) "Employer-sponsored health plan" means a health insurance plan offered by an employer either directly or through Utah's Health Marketplace (Avenue H).

(h) "Ex parte review" means a review process the agency conducts without contacting the recipient for information as defined in 42 CFR 457.343.

(i) "Federally Facilitated Marketplace" (FFM) means the entity 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.

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

(k) "Presumptive eligibility" means a period of time during which a child may receive CHIP benefits based on preliminary information that the child meets the eligibility criteria.

(l) "Quarterly Premium" means a payment that enrollees must pay every three months to receive coverage under CHIP.

(m) "Review month" means the last month of the eligibility certification period for an enrollee during which the eligibility agency determines an enrollee's eligibility for a new certification period.

(n) "Utah's Premium Partnership for Health Insurance" or "UPP" means the program described in Rule R414-320.

R382-10-3. Actions on Behalf of a Minor.

(1) A parent, legal guardian or an adult who assumes responsibility for the care or supervision of a child who is under 19 years of age may apply for CHIP enrollment, provide information required by this rule, or otherwise act on behalf of a child in all respects under the statutes and rules governing the CHIP program.

(2) If the child's parent, responsible adult, or legal guardian wants to designate an authorized representative, he must so indicate in writing to the eligibility agency.

(3) A child who is under 19 years of age and is independent of a parent or legal guardian may assume these responsibilities. The eligibility agency may not require a child who is independent to have an authorized representative if the child can act on his own behalf; however, the eligibility agency may designate an authorized representative if the child needs a representative but cannot make a choice either in writing or orally in the presence of a witness.

(4) Where the statutes or rules governing the CHIP program require a child to take an action, the parent, legal guardian, designated representative or adult who assumes responsibility for the care or supervision of the child is responsible to take the action on behalf of the child. If the parent or adult who assumes responsibility for the care or supervision of the child fails to take an action, the failure is attributable as the child's failure to take the action.

(5) The eligibility agency shall consider notice to the parent, legal guardian, designated representative, or adult who assumes responsibility for the care or supervision of a child to be notice to the child. The eligibility agency shall send notice to a child who assumes responsibility for himself.

R382-10-4. Applicant and Enrollee Rights and Responsibilities.

(1) A parent or an adult who assumes responsibility for the care or supervision of a child may apply or reapply for CHIP benefits on behalf of a child. A child who is independent may apply on his own behalf.

(2) If a person needs assistance to apply, the person may request assistance from a friend, family member, the eligibility agency, or outreach staff.

(3) The applicant must provide verification requested by the eligibility agency to establish the eligibility of the child, including information about the parents.

(4) Anyone may look at the eligibility policy manuals located on-line or at any eligibility agency office, except at outreach or telephone locations.

(5) If the eligibility agency determines that the child received CHIP coverage during a period when the child was not eligible for CHIP, the parent, child, or legal guardian who arranges for medical services on behalf of the child must repay the Department for the cost of services.

(6) The parent or child, or other responsible person acting on behalf of a child must report certain changes to the eligibility agency.

(a) The following changes are reportable within 10 calendar days of the day of the change:

(i) An enrollee begins to receive coverage or to have access to coverage under a group health plan or other health insurance coverage;

(ii) An enrollee leaves the household or dies;

(iii) An enrollee or the household moves out of state;
(iv) Change of address of an enrollee or the household; and
(v) An enrollee enters a public institution or an institution for mental diseases.
(b) Certain changes are reportable as part of the review process if these changes occurred anytime during the certification period and before the 10-day notice due date in the review month. A change in the following must be reported as part of the review process for any household member:
(i) Income source;
(ii) Gross income of $25 or more;
(iii) Tax filing status;
(iv) Pregnancy or termination of a pregnancy;
(v) Number of dependents claimed as tax dependents;
(vi) Earnings of a child;
(vii) Marital status; and
(viii) Student status of a child under 24 years of age.
(7) An applicant and enrollee may review the information that the eligibility agency uses to determine eligibility.
(8) An applicant and enrollee have the right to be notified about actions that the agency takes to determine their eligibility or continued eligibility, the reason the action was taken, and the right to request an agency conference or agency action as defined in Section R414-301-6 and Section R414-301-7.
(9) An enrollee in CHIP must pay quarterly premiums to the agency, and co-payments or co-insurance amounts to providers for medical services that the enrollee receives under CHIP.

R382-10-5. Verification and Information Exchange.
(1) The provisions of Section R414-308-4 apply to applicants and enrollees of CHIP.
(2) The Department and the eligibility agency shall safeguard applicant and enrollee information in accordance with Section R414-301-4.
(3) The Department or the eligibility agency may release information concerning applicants and enrollees and their households to other state and federal agencies to determine eligibility for other public assistance programs.
(4) The Department adopts and incorporates by reference 42 CFR 457.348, 457.350, and 457.380, October 1, 2012 ed.
(5) 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 CHIP 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 CHIP eligibility determination services.
(6) The Department and the eligibility agency shall release information to the Title IV-D agency and Social Security Administration to determine benefits.

R382-10-6. Citizenship and Alienage.
(1) To be eligible to enroll in CHIP, a child must be a citizen or national of the United States (U.S.) or a qualified alien.
(2) The provisions of Section R414-302-3 regarding citizenship and alien status requirements apply to applicants and enrollees of CHIP.
(3) 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 CS18 of the Utah CHIP State Plan.

R382-10-7. Utah Residence.
(1) The Department adopts and incorporates by reference, 42 CFR 457.320(d), October 1, 2012 ed. A child must be a Utah resident to be eligible to enroll in the program.
(2) An American Indian or Alaska Native child in a boarding school is a resident of the state where his parents reside. A child in a school for the deaf and blind is a resident of the state where his parents reside.
(3) A child is a resident of the state if he is temporarily absent from Utah due to employment, schooling, vacation, medical treatment, or military service.
(4) The child need not reside in a home with a permanent location or fixed address.

R382-10-8. Residents of Institutions.
(1) Residents of institutions described in Section 2110(b)(2)(A) of the Compilation of Social Security Laws are not eligible for the program.
(2) A child under the age of 18 is not a resident of an institution if he is living temporarily in the institution while arrangements are being made for other placement.
(3) A child who resides in a temporary shelter for a limited period of time is not a resident of an institution.

R382-10-9. Social Security Numbers.
(1) The eligibility agency may request an applicant to provide the correct Social Security Number (SSN) or proof of application

for a SSN for each household member at the time of application for the program. The eligibility agency shall use the SSN in accordance with the requirements of 42 CFR 457.340(b), October 1, 2012 ed., which is incorporated by reference.

(2) The eligibility agency shall require that each applicant claiming to be a U.S. citizen or national provide their SSN for the purpose of verifying citizenship through the Social Security Administration in accordance with Section 2105(c)(9) of the Compilation of the Social Security Laws.

(3) The eligibility agency may request the SSN of a lawful permanent resident alien applicant, but may not deny eligibility for failure to provide an SSN.

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

R382-10-10. Creditable Health Coverage.

(1) To be eligible for enrollment in the program, a child must meet the requirements of Sections 2110(b) of the Compilation of Social Security Laws.

(2) A child who is covered under a group health plan or other health insurance that provides coverage in Utah, including coverage under a parent's or legal guardian's employer, as defined in 29 CFR 2590.701-4, July 1, 2013 ed., is not eligible for CHIP assistance.

(3) A child who has access to health insurance coverage, where the cost to enroll the child in the least expensive plan offered by the employer is less than 5% of the countable MAGI-based income for the individual, is not eligible for CHIP. The child is considered to have access to coverage even when the employer only offers coverage during an open enrollment period, and the child has had at least one chance to enroll.

(4) An eligible child who has access to an employer-sponsored health plan, where the cost to enroll the child in the least expensive plan offered by the employer equals or exceeds 5% of the countable MAGI-based income for the individual may choose to enroll in either CHIP or UPP.

(a) To enroll in UPP, the child must meet UPP eligibility requirements.

(b) If the UPP eligible child enrolls in the employer-sponsored health plan or COBRA coverage, but the plan does not include dental benefits, the child may receive dental-only benefits through CHIP.

(c) If the employer-sponsored health plan or COBRA coverage includes dental, the applicant may choose to enroll the child in the dental plan and receive an additional reimbursement from UPP, or receive dental-only benefits through CHIP.

(d) A child enrolled in CHIP who gains access to or enrolls in an employer-sponsored health plan may switch to the UPP program if the child meets UPP eligibility requirements.

(5) The cost of coverage includes the following:

(a) the premium;

(b) a deductible, if the employer-sponsored plan has a deductible; and

(c) the cost to enroll the employee, if the employee must be enrolled to enroll the child.

(6) Subject to the provisions published in 42 CFR 457.805(b), October 1, 2015 ed., which the Department adopts and incorporates by reference, the eligibility agency shall deny eligibility and impose a 90-day waiting period for enrollment under CHIP if the applicant or a custodial parent voluntarily terminates health insurance that provides coverage in Utah within the 90 days before the application date. In addition, the agency may not apply a 90-day waiting period in the following situations:

(a) a non-custodial parent voluntarily terminates coverage;

(b) the child is voluntarily terminated from insurance that does not provide coverage in Utah;

(c) the child is voluntarily terminated from a limited health insurance plan;

(d) a child is terminated from a custodial parent's insurance because ORS reverses the forced enrollment requirement due to the insurance being unaffordable;

(e) voluntary termination of COBRA;

(f) voluntary termination of Utah Comprehensive Health Insurance Pool coverage; or

(g) voluntary termination of UPP reimbursed, employer-sponsored coverage.

(7) If the 90-day ineligibility period for CHIP ends in the month of application, or by the end of the month that follows, the eligibility agency shall determine the applicant's eligibility.

(a) If eligible, enrollment in CHIP begins the day after the 90-day ineligibility period ends.

(b) If the 90-day ineligibility period does not end by the end of the month that follows the application month, the eligibility agency shall deny CHIP eligibility.

(8) The Department shall comply with the provisions of enrollment after the waiting period in accordance with 42 CFR 457.340, October 1, 2015 ed., which the Department adopts and incorporates by reference.

(9) A child with creditable health coverage operated or financed by Indian Health Services is not excluded from enrolling in CHIP.

(10) A child who has access to state-employee health insurance as defined in 42 CFR 457.310 is not eligible for CHIP assistance.

R382-10-11. Household Composition and Income Provisions.

(1) The Department adopts and incorporates by reference, 42 CFR 457.315 (October 1, 2015), regarding the household composition and income methodology to determine eligibility for CHIP.

(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) Any individual described in Subsection R382-10-11(1) who is temporarily absent solely by reason of employment, school, training, military service, or medical treatment, or who will return home to live within 30 days from the date of application, is part of the household.

(3) 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.

(4) 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.

(5) 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.

(6) The eligibility agency determines eligibility by deducting an amount equal to 5% of the federal poverty guideline, as defined in 42 CFR 435.603(d)(4).

R382-10-12. Age Requirement.

(1) A child must be under 19 years of age sometime during the application month to enroll in the program. An otherwise eligible child who turns 19 years of age during the application month may receive CHIP for the application month and the four-day grace period.

(2) The month in which a child turns 19 years of age is the last month of eligibility for CHIP enrollment.

R382-10-13. Budgeting.

(1) The eligibility agency determines countable household income according to MAGI-based methodology as required by 42 CFR 457.315.

(2) The eligibility agency shall determine a child's eligibility and cost sharing requirements prospectively for the upcoming eligibility period at the time of application and at each renewal for continuing eligibility.

(a) The eligibility agency determines prospective eligibility by using the best estimate of the household's average monthly income expected to be received or made available to the household during the upcoming eligibility period.

(b) The eligibility agency shall include in its estimate, 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.

(c) The eligibility agency prorates income that is received less often than monthly over the eligibility period to determine an average monthly income.

(3) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing. The eligibility agency may use a combination of methods to obtain the most accurate best estimate. The best estimate may be a monthly amount that is expected to be received each month of the eligibility period, or an annual amount that is prorated over the eligibility period. Different methods may be used for different types of income received in the same household.

(4) The eligibility agency determines farm and self-employment income by using the individual's recent tax return forms or other verifications the individual can provide. If tax returns are not available, or are not reflective of the individual's current farm or self-employment income, the eligibility agency may request income information from a recent time period during which the individual had farm or self-employment income. The eligibility agency deducts the same expenses from gross income that the Internal Revenue Service allows as self-employment expenses to determine net self-employment income, if those expenses are expected to occur in the future.

R382-10-14. Assets.

An asset test is not required for CHIP eligibility.

R382-10-15. Application and Eligibility Reviews.

(1) The Department adopts and incorporates by reference 42 CFR 457.330, 457.340, 457.343, and 457.348, October 1, 2013 ed.

(2) The provisions of Section R414-308-3 apply to applicants for CHIP, except for Subsection R414-308-3(10) and the three months of retroactive coverage.

(3) Individuals can apply without having an interview. The eligibility agency may interview applicants and enrollee's, the parents or spouse, and any adult who assumes responsibility for the care or supervision of the child, when necessary to resolve discrepancies or to gather information that cannot be obtained otherwise.

(4) The eligibility agency shall complete a periodic review of an enrollee's eligibility for CHIP medical assistance in accordance with the requirements of 42 CFR 457.343.

(5) If an enrollee fails to respond to a request for information to complete the review during the review month, the agency shall end the enrollee's eligibility effective at the end of the review month and send proper notice to the enrollee.

(a) If the enrollee responds to the review or reapplies within three calendar months of the review closure date, the eligibility agency shall treat the response as a new application without requiring the enrollee to reapply. The application processing period then applies for this new request for coverage.

(b) If the enrollee is determined eligible based on this reapplication, the new certification period begins the first day of the month in which the enrollee contacts the agency to complete the review if verification is provided within the application processing period. The four day grace period may apply. If the enrollee fails to return verification within the application processing period, or if the enrollee is determined ineligible, the eligibility agency shall send a denial notice to the enrollee.

(c) The eligibility agency may not continue eligibility while it makes a new eligibility determination.

(6) Except as defined in R382-10-15(5), the enrollee must reapply for CHIP if the enrollee's case is closed for one or more calendar months.

(7) If the eligibility agency sends proper notice of an adverse decision during the review month, the agency shall change eligibility for the month that follows.

(8) If the eligibility agency does not send proper notice of an adverse change for the month that follows, the agency shall extend eligibility to that month. The eligibility agency shall send proper notice of the effective date of an adverse decision. The enrollee does not owe a premium for the due process month.

(9) If the enrollee responds to the review in the review month and the verification due date is in the month that follows, the eligibility agency shall extend eligibility to the month that follows. The enrollee must provide all verification by the verification due date.

(a) If the enrollee 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 enrollee does not provide all requested verification by the verification due date, the eligibility agency shall end eligibility effective at the end of the month in which the eligibility agency sends proper notice of the closure.

(c) If the enrollee returns all verification after the verification due date and before the effective closure date, the eligibility agency shall treat the date that it receives all verification as a new application date. The eligibility agency shall determine eligibility and send a notice to the enrollee.

(d) The eligibility agency may not continue eligibility while it determines eligibility. The new certification date for the application is the day after the effective closure date if the enrollee is found eligible.

(10) The eligibility agency shall provide ten-day notice of case closure if the enrollee is determined to be ineligible or if the enrollee fails to provide verification by the verification due date.

(11) If eligibility for CHIP enrollment ends, the eligibility agency shall review the case for eligibility under any other medical assistance program without requiring a new application. The eligibility agency may request additional verification from the household if there is insufficient information to make a determination.

(12) An applicant must report at application and review whether any of the children in the household for whom enrollment is being requested have access to or are covered by a group health plan, other health insurance coverage, or a state employee's health benefits plan.

(13) The eligibility agency shall deny an application or review if the enrollee fails to respond to questions about health insurance coverage for children whom the household seeks to enroll or renew in the program.

R382-10-16. Eligibility Decisions.

(1) The Department adopts and incorporates by reference 42 CFR 457.350, October 1, 2013, ed., regarding eligibility screening.

(2) The eligibility agency shall determine eligibility for CHIP within 30 days of the date of application. If the eligibility agency cannot make a decision in 30 days because the applicant fails to take a required action and requests additional time to complete the application process, or if circumstances beyond the eligibility agency's control delay the eligibility decision, the eligibility agency shall document the reason for the delay in the case record.

(3) The eligibility agency may not use the time standard as a waiting period before determining eligibility, or as a reason for denying eligibility when the agency does not determine eligibility within that time.

(4) The eligibility agency shall complete a determination of eligibility or ineligibility for each application unless:

(a) the applicant voluntarily withdraws the application and the eligibility agency sends a notice to the applicant to confirm the withdrawal;

(b) the applicant died; or

(c) the applicant cannot be located or does not respond to requests for information within the 30-day application period.

(5) The eligibility agency shall redetermine eligibility every 12 months.

(6) At application and review, the eligibility agency shall determine if any child applying for CHIP enrollment is eligible for coverage under Medicaid.

(a) A child who is eligible for Medicaid coverage is not eligible for CHIP.

(b) An eligible child who must meet a spenddown to receive Medicaid and chooses not to meet the spenddown may enroll in CHIP.

(7) If an enrollee asks for a new income determination during the CHIP certification period and the eligibility agency finds the child is eligible for Medicaid, the agency shall end CHIP coverage and enroll the child in Medicaid.

R382-10-17. Effective Date of Enrollment and Renewal.

(1) Subject to the limitations in Section R414-306-6, Section R382-10-10, and the provisions in Subsection R414-308-3(7), the effective date of CHIP enrollment is the first day of the application month.

(2) If the eligibility agency receives an application during the first four days of a month, the agency shall allow a grace enrollment period that begins no earlier than four days before the date that the agency receives a completed and signed application.

(a) If the eligibility agency allows a grace enrollment period that extends into the month before the application month, the days of the grace enrollment period do not count as a month in the 12-month enrollment period.

(b) During the grace enrollment period, the individual must receive medical services, meet eligibility criteria, and have an emergency situation that prevents the individual from applying. The Department may not pay for any services that the individual receives before the effective enrollment date.

(3) For a family who has a child enrolled in CHIP and who adds a newborn or adopted child, the effective date of enrollment is the date of birth or placement for adoption if the family requests the coverage within 60 days of the birth or adoption. If the family makes the request more than 60 days after the birth or adoption, enrollment in CHIP becomes effective the first day of the month in which the date of report occurs, subject to the limitations in Section R414-306-6, Section R382-10-10, and the provisions of Subsection R382-10-17(2).

(4) For an individual who transfers from the Federally Facilitated Marketplace (FFM), the effective date of enrollment to add a newborn or adopted child is the date of birth or placement for adoption if the individual requests FFM coverage within 60 days of the birth or adoption. If the request is more than 60 days after the birth or adoption, enrollment in CHIP becomes effective the first day of the month in which the date of report occurs, subject to the limitations in Section R414-306-6, Section R382-10-10, and the provisions of Subsection R382-10-17(2).

(5) The effective date of enrollment for a new certification period after the review month is the first day of the month after the review month, if the review process is completed by the end of the review month. If a due process month is approved, the effective date of enrollment for a renewal is the first day of the month after the due process month if the review process is completed by the end of the due process month. The enrollee must complete the review process and continue to be eligible to be reenrolled in CHIP at review.

R382-10-18. Enrollment Period and Benefit Changes.

(1) Subject to the provisions in Subsection R382-10-18(2), a child determined eligible for CHIP receives 12 months of coverage that begins with the effective month of enrollment.

(2) CHIP coverage may end or change before the end of the 12-month certification period if the child:

(a) turns 19 years of age;

(b) moves out of the state;

(c) becomes eligible for Medicaid;

(d) leaves the household;

(e) is not eligible, or is eligible for a different plan due to a change described in Subsection R382-10-4(6)(b);

(f) begins to be covered under a group health plan or other health insurance coverage;

(g) gains access to state-employee health benefits as defined in 42 CFR 457.310;

(h) enters a public institution or an institution for mental disease;

(i) fails to respond to a request to verify access to employer-sponsored health coverage;

(j) fails to respond to a request to verify reportable changes as described in Subsection R382-10-4(6)(b); or

(k) does not pay the quarterly premium.

(3) The agency evaluates changes and may re-determine eligibility when it receives a change report as described in Subsection R382-10-4(6). If the agency requests verification of the change, the agency shall give the client at least 10 days to provide verification. The agency shall provide proper notice of an adverse action.

(4) If a client reports a change that occurs during the certification period and requests a redetermination, the agency shall re-determine eligibility.

(a) If an enrollee gains access to health insurance under an employer-sponsored plan or COBRA coverage, the enrollee may switch to UPP. The enrollee must report the health insurance within 10 calendar days of enrolling, or within 10 calendar days of when coverage begins, whichever is later. The employer-sponsored plan must meet UPP criteria.

(b) If the change would cause an adverse action, eligibility shall remain unchanged through the end of the certification period.

(c) If the change results in a better benefit, the agency shall take the following actions:

(i) If the change makes the enrollee eligible for Medicaid, the eligibility agency shall end CHIP eligibility and enroll the child in Medicaid.

(ii) If the change results in a lower premium, the decrease is effective as follows:

(A) The premium change is effective the month of report if income decreased that month and the family provides timely verification of income;

(B) The premium change is effective the month following the report month if the decrease in income is for the following month and the family provides timely verification of income;

(C) The premium change is effective the month in which verification of the decrease in income is provided, if the family does not provide timely verification of income.

(5) Failure to make a timely report of a reportable change may result in an overpayment of benefits and case closure.

R382-10-19. Quarterly Premiums.

(1) Each family with children enrolled in the CHIP program must pay a quarterly premium based on the countable income of the family during the first month of the quarter.

(a) The eligibility agency may not charge a premium to a child who is American Indian or Alaska Native.

(b) A family with countable income up to 150% of the federal poverty level must pay a quarterly premium of $30.

(c) A family with countable income greater than 150% and up to 200% of the federal poverty level must pay a quarterly premium of $75.

(d) The agency shall charge the family the lowest premium amount when the family has two or more children, and those children qualify for different quarterly premium amounts.

(2) The eligibility agency shall end CHIP coverage and assess a $15 late fee to a family who does not pay its quarterly premium by the premium due date.

(3) The agency may reinstate coverage if the family pays the premium and the late fee by the last day of the month immediately

following the termination.

(4) A child is ineligible for CHIP for three months if CHIP is terminated for failure to pay the quarterly premium. The child must reapply at the end of the three months. If eligible, the agency shall approve eligibility without payment of the past due premiums or late fee.

(5) The eligibility agency may not charge the household a premium during a due process month associated with the periodic eligibility review.

(6) The eligibility agency shall assess premiums that are payable each quarter for each month of eligibility.

R382-10-20. Termination and Notice.

(1) The eligibility agency shall notify an applicant or enrollee in writing of the eligibility decision made on the application or periodic eligibility review.

(2) The eligibility agency shall notify an enrollee in writing ten calendar days before the effective date of an action that adversely affects the enrollee's eligibility.

(3) Notices under Section R382-10-20 shall provide the following information:

(a) the action to be taken;

(b) the reason for the action;

(c) the regulations or policy that support the action when the action is a denial, closure or an adverse change to eligibility;

(d) the applicant's or enrollee's right to a hearing;

(e) how an applicant or enrollee may request a hearing; and

(f) the applicant's or enrollee's right to represent himself, use legal counsel, a friend, relative, or other spokesperson.

(4) The eligibility agency need not give ten-day notice of termination if:

(a) the child is deceased;

(b) the child moves out-of- state and is not expected to return;

(c) the child enters a public institution or an institution for mental diseases; or

(d) the child's whereabouts are unknown and the post office has returned mail to indicate that there is no forwarding address.

R382-10-21. Case Closure or Withdrawal.

(1) The eligibility agency shall end a child's enrollment upon enrollee request or upon discovery that the child is no longer eligible. An applicant may withdraw an application for CHIP benefits any time before the eligibility agency makes a decision on the application.

(2) The eligibility agency shall comply with the requirements of 42 CFR 457.350(i), regarding transfer of the electronic file for the purpose of determining eligibility for other insurance affordability programs.

R382-10-22. Public Health Emergency Provisions.

(1) During the public health emergency declared by the Secretary of Health and Human Services on January 27, 2020, the Department will continue coverage of children enrolled in CHIP.

(a) This applies to an individual who is eligible and enrolled on March 18, 2020, the date of enactment of Pub. L. No. 116 127, or who subsequently becomes eligible and enrolled in medical assistance during the emergency period and any extensions.

(b) Coverage for an individual eligible for CHIP during the public health emergency period will end only under the following circumstances:

(i) when a beneficiary is no longer a Utah resident;

(ii) upon a beneficiary's request; or

(iii) upon a beneficiary's death. Coverage continues through the date of death.

(2) An individual is not required to pay CHIP Premiums through the duration of the emergency period and any extensions. The Department will refund the individual any premiums collected during the emergency period and any extensions.

(3) The Department shall exclude the following from an individual's income:

(a) $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 XXI of the Social Security Act; and

(b) recovery rebates for individuals as defined in Section 2201 of the Cares Act, Pub. L. No. 116 136, for programs established under Title XXI of the Social Security Act. These rebates are treated as a refundable tax credit and may be paid in advance or upon filing a 2020 tax return.

(4) 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.

(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.

(5) 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.

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

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

(6) An individual is not required to pay any cost-sharing fees associated with Coronavirus (COVID-19) testing services and treatments, including vaccines, specialized equipment, and therapies during the duration of the emergency period.

KEY: children's health benefits
Date of Enactment or Last Substantive Amendment: September 16, 2020
Notice of Continuation: April 11, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-40

State of Utah
Administrative Rule Analysis
Revised June 2022

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-52**	**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:		
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Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
R414-52 Optometry Services
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 by rule vision services for eligible Medicaid members, and 42 CFR 440.60 allows Medicaid to cover vision services performed by a licensed optometrist.
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 optometry services for Medicaid members as described in the Vision Care Services Provider Manual and in the Medicaid State Plan.

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:**	
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.
R414-52. Optometry Services.
R414-52-1. Introduction.

The Optometry Services Program provides a scope of services for Medicaid recipients in accordance with the Vision Care Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.

KEY: Medicaid, optometry
Date of Enactment or Last Substantive Amendment: July 16, 2015
Notice of Continuation: April 10, 2018
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:	**R414-53**	**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:

R414-53 Eyeglasses Services

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 by rule vision services for eligible Medicaid members, and 42 CFR 440.120(d) defines eyeglasses in relation to Medicaid coverage.

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 eyeglasses services for Medicaid members as described in the Vision Care Services Provider Manual and in the Medicaid State Plan.

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:**	

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R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-53. Eyeglasses Services.
R414-53-1. Introduction.

The Eyeglasses Services Program provides a scope of services for Medicaid recipients in accordance with the Vision Care Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.

KEY: Medicaid, eyeglasses
Date of Enactment or Last Substantive Amendment: July 16, 2015
Notice of Continuation: April 10, 2018
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3