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

**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)(a) 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.

(b) If a member must pay one of the following fees to receive Medicaid, the eligibility agency shall determine eligibility and notify the member of the amount owed for coverage. The eligibility agency shall grant eligibility if it receives the required payment, or in the case of a spenddown or cost-of-care contribution for waivers, if the member sends proof of incurred medical expenses equal to the payment. The fees a member 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.

(2) A required spenddown, MWI premium, or cost-of-care contribution is due each month for a member to receive Medicaid coverage. A pregnant member or member in their postpartum period is only required to meet the spenddown once and remains eligible through the remainder of the postpartum period.

(3) The member 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 member owes.

(4) For ongoing months of eligibility, the member 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 member 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 member meets the required payment. If the member does not meet the required payment by the due date, the member may reapply for retroactive benefits if that month is within the retroactive period of the new application date.

(5) A member 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 member 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 member owes the facility.

(6) Even if the eligibility agency does not close a medical assistance case, no eligibility exists in a month in which the member fails to meet a required spenddown, MWI premium, or cost-of-care contribution for home and community-based waiver services.

(7) The eligibility agency shall continue eligibility for a resident of a nursing home even if 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.

(8) The eligibility period ends on:

(a) the last day of the month in which the eligibility agency determines that the member 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 if the member 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 member 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 12 months 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;

(f) for children under 19 years of age, the earlier of:

(i) the end of the 12-month period beginning on the date the member is determined eligible;

(ii) the date the member reaches 19 years of age;

(iii) the date the member ceases to be a state resident; or

(iv) the date the member loses lawful permanent residence status as defined in Subsection R414-302-3(2); or

(g) the date the member dies.

(9) 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 if 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 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.

(10) 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.

(11) The eligibility agency shall complete a periodic review of a member's eligibility for medical assistance in accordance with 42 CFR 435.916 (2024). 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 member continues to be eligible for medical assistance.

(12) For non-MAGI-based coverage groups, the eligibility agency may complete an eligibility review more frequently if it:

(a) has information about anticipated changes in the member's circumstances that may affect eligibility;

(b) knows the member has fluctuating income;

(c) completes a review for other assistance programs that the member receives; or

(d) needs to meet workload demands.

(13) If a member 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 member.

(a) If the member 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 member to reapply. The application processing period shall apply for the new request for coverage.

(b) If the member becomes eligible based on this reapplication, the member's eligibility becomes effective the first day of the month after the closure date if verification is provided timely. If the member fails to return verification timely or if the member is determined to be ineligible, the eligibility agency shall send a denial notice to the member.

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

(14) If the eligibility agency sends proper notice of an adverse decision in the review month, the agency shall change eligibility for the following month.

(15) 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.

(16) If the member 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 member must provide verification by the verification due date.

(a) If the member provides requested verification by the verification due date, the eligibility agency shall determine eligibility and send proper notice of the decision.

(b) If the member does not provide 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 member returns 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 member.

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

(18) The eligibility agency may not extend coverage under certain medical assistance programs in accordance with state and federal law. The agency shall notify the member before the effective closure date.

(a) If the eligibility agency determines that the member qualifies for a different medical assistance program, the agency shall notify the member. Otherwise, the agency shall end eligibility when the permitted time period for the program expires.

(b) If the member provides information before the effective closure date that indicates the member may qualify for another medical assistance program, the eligibility agency shall treat the information as a new application. If the member contacts the eligibility agency after the effective closure date, the member 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.

**KEY: public assistance programs, applications, eligibility, Medicaid**

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